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# Rules of Department of Social Services

## Division 70—Division of Medical Services

### Chapter 10—Nursing Home Program

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**Title 13—DEPARTMENT OF  
SOCIAL SERVICES**

**Division 70—Division of Medical  
Services**

**Chapter 10—Nursing Home Program**

**13 CSR 70-10.005 Reasonable Cost-  
Related Reimbursement Plan for Long-  
Term Care**

*PURPOSE: This rule establishes a payment plan for nursing home care required by the Code of Federal Regulations (42 CFR 447.273–447.316). The plan describes cost principles to be followed by Title XIX nursing home providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing of the cost reports.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law. The forms mentioned in this rule follow 13 CSR 70-10.010.*

(1) Objectives.

(A) Uniform Plan. The provisions embodied in this rule define a system of reasonable cost-related reimbursement for long-term care (LTC) facilities participating in the Missouri Title XIX Medical Assistance Program that treats all providers of nursing care and services on a uniform basis.

(B) Adequacy of Reimbursement. Consistent with efficiency, economy and quality of care, the plan is to accomplish the purpose of adequate and reasonable reimbursement for services rendered to persons eligible for medical assistance under the Missouri Title XIX program.

(C) Improvement of Expenditure Forecasting. Capability of Title XIX management to forecast expenditures for LTC will be improved.

(2) Scope.

(A) Participating Providers. Reasonable cost-related reimbursement for LTC and services is applicable to those facilities with a valid participation agreement in effect on or after July 1, 1976, with the Missouri Department of Social Services. Areas of a facility certified to participate in the Title

XIX program by the Department of Social Services or other certifying authority approved by the Department of Social Services and the Department of Health, Education and Welfare (HEW) are covered within this rule. The provisions of this rule shall become effective January 1, 1980; however, year-end cost reports for fiscal years beginning prior to January 1, 1980, shall be prepared in accordance with the prior plan except in those areas where additional covered services have been added by this plan. These additional services shall be handled in a separate line item in the cost report. The provisions contained in this rule shall not have any retroactive effect on the cost reports or determination of any retrospective payment for fiscal years beginning prior to May 11, 1975.

(B) Allowable Costs. Each provider's total allowable costs (TACs) will be determined by the Department of Social Services from cost reports submitted on a fiscal-year basis. The fiscal year, which will be each provider's fiscal year, should coincide with the tax year used by the provider in submitting federal income tax reports.

(C) Eligible Recipients. This plan applies only to allowable costs incurred by eligible facilities for eligible recipients certified to medically require long-term, skilled, intermediate care or care for the mentally retarded, or a combination of these.

(3) Changes to Plan. Changes to the plan may be made by the Department of Social Services. Representatives of participating facilities will have an opportunity to make recommendations. All these changes will be subject to approval by the secretary of HEW and in accordance with sections 536.021 and 536.025, RSMo.

(4) Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve (12)-month period which is to be designated as the provider's fiscal year (see subsection (2)(B) of this rule). An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed forms shall be submitted by each provider within ninety (90) days following the close of its fiscal year.

2. Unless adequate documentation in the following areas has been filed previously with the department, authenticated copies of the following documents must be submitted with the cost report: authenticated copies of all leases related to the activities of the facility, all management contracts, all contracts with

consultants, federal and state income tax returns for the fiscal year and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. Following the ninety (90)-day period, interim payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with these rules, the interim payments that were withheld will be released.

5. If requested in writing, a reasonable extension of the filing date may be granted for good cause shown.

6. The termination by a provider of participation in the program or a change of ownership requires that the provider submit a cost report for the period ending with the date of termination or change. The cost report is due within forty-five (45) days of the date of termination or change. If requested in writing, a reasonable extension of the filing date may be granted for good cause shown.

(B) Certification of Cost Reports.

1. The accuracy and validity of any cost report, whether annual or interim, must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of this authorization): for an incorporated body, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or a sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider(s):

I hereby certify that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared by \_\_\_\_\_

(Provider name(s) and number(s))

for the cost report period beginning \_\_\_\_\_, 19\_\_ and ending \_\_\_\_\_, and that to the best of my knowledge and belief, it is true, correct, and complete statement prepared



from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signature) (Title) (Date)

(C) Interim Reports.

1. From the beginning of its fiscal year, a provider, at its election, may submit cumulative quarterly cost reports. Insurance premiums, property taxes, professional fees and similar items shall be prorated in this report in order to avoid any distortion of allowable costs.

2. An interim cost report may be submitted for consideration whenever a participating LTC facility changes the level-of-care it has been certified to provide.

3. Whenever additional beds are added, licensed and certified to an existing facility, the facility may file an interim cost report.

(D) Adequacy of Records.

1. The records and accounting procedures of a provider must be adequate to substantiate purposes of review and audit as may be necessary in accordance with this plan.

2. At all reasonable times, the provider shall make available to the department and its duly authorized agent, including federal agents from HEW, records as are necessary to permit review and audit of the provider's cost reports. Failure to do so may lead to the penalty stated in paragraph (4)(A)4. of this rule.

3. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(5) Principles of Reasonable Cost-Related Reimbursement, Allowable Costs.

(A) General Provisions.

1. Nursing facilities participating in the Missouri Medicaid program which provide skilled or intermediate care, or intermediate care facility/mentally retarded (ICF/MR) care, or a combination of these, shall be reimbursed based upon the allowable costs of the individual nursing facility. These costs must be related to ordinary and necessary care for the level-of-care actually provided.

2. In addition to reimbursement of allowable costs, a proprietary provider shall be paid a reasonable return on owner's net equity (see section (14)).

3. Allowable costs means those costs of the provider which are allowable for allocation to the Medicaid program based upon the principles established in this rule.

4. The allowability of costs not addressed specifically in this rule will be

determined by the director, Department of Social Services, in a manner as to assure uniform application to all providers. This determination may be based upon criteria such as the *Medicare Provider Reimbursement Manual* (HIM-15).

5. Provider means a nursing home, or other facility as may be designated by the Department of Social Services, duly licensed and certified to participate in the Title XIX program by appropriate state agencies to furnish nursing and other care to individuals who by reason of illness, physical infirmities or advanced age are unable to care for themselves.

6. Payments to providers shall be based upon an individual accounting of the allowable costs of operation of each provider. The Department of Social Services shall have authority to require uniform accounting and reporting procedures as it deems necessary. As a minimum, standardized definitions, accounting, statistical and reporting procedures as well as expense classifications are to be in accordance with widely accepted understanding and use in health care institutions.

7. A participating nursing home is a provider which has entered into an agreement with the Department of Social Services to accept payments based upon the principles of reimbursement described in this rule and not charge the eligible recipient or any other person for covered items and services except in personal items.

8. A reasonable cost in each related cost area will be determined by the director of the Department of Social Services pursuant to section 208.152, RSMo. At his/her option, the director may follow guidelines set forth in the *Medicare and Medicaid Provider Manual* (HIM-15, Section 904), "Criteria for Determining Reasonable Compensation General," as applicable to the operation of the program by Missouri.

(B) Compensation of Owners.

1. Regardless of whether the provider is a corporation, partnership, proprietorship or otherwise, a reasonable allowance of compensation of services of owners shall be an allowable cost, provided the services are actually performed in a necessary function.

2. Compensation shall mean the total benefit received by the owner for the services s/he renders to the facility including: direct payments for managerial, administrative, professional and other services; amount paid by the provider for the personal benefit of the owner; the cost of assets and services which the owner receives from the provider; deferred compensation; and additional amounts determined to be the reasonable value of the services rendered by sole propri-

etors or partners and not paid by any method enumerated in this section.

3. Reasonableness of compensation may be determined by reference to or in comparison with compensation paid for comparable services and responsibilities in comparable institutions, or it may be determined by other appropriate means such as the *Medicare and Medicaid Provider Reimbursement Manual* (HIM-15).

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility; had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(C) Covered Services and Supplies.

1. Skilled nursing facility (SNF) and ICF services and supplies covered by this plan are those found in 42 CFR 442.100—442.516 which include, among other services, the regular room, dietary and nursing services or any other services that are required for standards of participation or certification; also included are minor medical and surgical supplies and the use of equipment and facilities. Services set out in subparagraphs (5)(C)1.G. and H. of this rule shall be covered services effective January 1, 1980. These items include, but are not limited to, the following:

A. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray services and enemas;

B. Items which are furnished routinely and relatively uniformly to all recipients, for example, gowns, water pitchers, basins and bed pans;

C. Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities such as alcohol, applicators, cotton balls, and bandaids, antacids, aspirins (and other non-legend drugs ordinarily kept on hand), suppositories and tongue depressors;

D. Items which are utilized by individual recipients, but which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable, nondepreciable medical equipment;

E. Additional items as specified in the appendix to this plan when provided to the patient;

F. Special dietary supplements used for tube feeding or oral feeding such as elemental high nitrogen diet including dietary supplements written as a prescription item by a physician;

G. All laundry services including personal laundry; and

H. All general personal care services which are furnished routinely and relatively uniformly to all recipients for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service.

(I) All consultive services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report, as specified in paragraph (4)(A)2. of this rule. Failure to do so will result in the penalties specified in paragraph (4)(A)4. of this rule.

(II) All services and supplies not included in allowable costs shall be treated as services and supplies not covered by the Medicaid program.

(III) The provider may collect from recipients, their relatives or from the recipient's personal needs fund only charges for personal items, noncovered services and supplies and prescription drugs not on the formulary.

(D) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business, including items that are used in a normal standby or emergency capacity, is an allowable cost.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the program basis of the asset and prorated over the estimated useful life of the asset using the straight line method of depreciation from the date initially put into service.

3. The program basis of assets shall be lower of the book value of the provider, fair market value at the time of acquisition or the recognized Internal Revenue Service (IRS) tax basis. Donated assets will be allowed basis to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a nursing home facility and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the Medicaid program and the nursing home facility in ratio to Medicaid recipients.

4. Allowable methods of depreciation shall be limited to the straight line method.

The depreciation method used for an asset under the Medicaid program need not correspond to the method used by a provider for non-Medicaid purposes; however, useful life shall be the same as the provider claims for IRS purposes. Component part depreciation is optional and allowable under this plan.

5. Historical cost is the cost incurred by the provider in acquiring the asset and to prepare it for use except as provided for in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees, consulting fees and related legal fees. Where a provider has elected for federal income tax purposes to expense certain items, such as interest and taxes during construction, the historical cost basis for Medicaid depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off these costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this plan, any asset costing less than three hundred dollars (\$300) or having a useful life of one (1) year or less may be expensed and not capitalized at the option of the provider.

6. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of the undepreciated cost basis of the traded asset plus the cash paid and subsection (10)(A) shall not apply.

7. For the purpose of determining allowance for depreciation under the Medicaid program, the cost basis of a facility purchased as an ongoing operation after July 1, 1976, shall be the price paid by the purchaser or the appraised value, whichever is lower. If the purchaser cannot demonstrate that the sale was a bona fide sale, the cost basis of the seller shall be determined on the basis of the value reported to IRS for the year immediately preceding the sale.

8. Subject to the principles enumerated in this subsection, the cost basis usable for depreciation of the facility to the purchaser shall be the lower of the purchaser's book value for the facility, the recognized IRS tax basis or the depreciable cost as determined in paragraph (5)(D)7.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred thousand dollars (\$100,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures are disallowed by the provisions of federal Social Security Act,

Section 1122(B), Social Security Amendments of 1972, Sections 221(B) and (D) or for failure to comply with any other federal act that promulgates a limitation on reimbursement for capital expenditures under federal or state legislation.

(E) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short-term. This is usually for purposes as working capital for normal operating expense. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment and capital improvements. Generally, loans for capital purposes are long-term loans.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost under the Medicaid program, interest (including finance charges, prepaid costs and discount) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claimed, and necessary and proper for the operation, maintenance or acquisition of the provider's facilities.

5. Necessary, as used in these rules, means that the interest be incurred on a loan made to satisfy a financial need of the provider and for a purpose reasonably related to recipient care. Loans which result in excess of funds or investments would not be considered necessary.

6. Proper, as used in these rules, means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

7. Interest on loans to providers by proprietors and general partners shall not be an allowable cost because these loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. Interest on loans to providers by limited partners or minority stockholders shall be an allowable cost at a rate not in excess of a reasonable rate. If a provider operated by members of a religious

order borrows from the order, interest paid to the order shall be an allowable cost.

8. Income from a provider's qualified retirement fund shall be excluded in consideration of the per-diem rate.

9. A provider shall amortize finance charges, prepaid interest or discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance where the time period is in excess of twelve (12) months.

10. Usual and customary costs incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

11. Usual and customary costs include, but are not limited to, lender's finance charges or fees, title and recording fees, appraisal fees, legal fees, escrow fees and closing costs.

12. Loan costs shall be allowable costs only to the extent that they meet the criteria established in this rule for the allowance of interest expense in general.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred thousand dollars (\$100,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost if those capital expenditures are disallowed by the secretary of Health and Human Services (HHS) for failure to comply with the provisions of federal Social Security Act, Section 1122(B), Social Security Amendments of 1972, Sections 221(B) and (D), or for failure to comply with any other federal or state requirement that promulgates a limitation on reimbursement for capital expenditures.

(F) Rental Costs.

1. Rental costs of land, buildings, furnishings and equipment are allowable costs provided that the rented items are reasonable, necessary and not in essence a purchase of those assets.

2. Necessary rental items are those which are pertinent to the operation and sound conduct of the provider, including items that are used in a normal standby or emergency capacity.

3. Reasonable rental amounts are the lesser of those which are actually paid or those that would be paid to an unrelated party for use of the same property.

4. Determination of reasonableness in individual cases may be established by affidavits of competent, impartial experts who are familiar with the current rentals in the community.

5. The test of reasonableness shall take into account the agreement between the

owner and the tenant regarding the payment of related property costs.

6. In the case of rental costs paid to individuals or organizations related to the provider by common ownership or control (or to the lessors or an ongoing facility), the rental amounts shall not exceed the lesser of actual or reasonable costs to constitute allowable costs (see paragraph (5)(F)3.).

7. Related to the provider, common ownership and control have the same meaning as defined in paragraphs (5)(N)2. and 3.

8. Lessor of an ongoing facility means any owner of rented property who had used the property to participate in the Medicaid program on or after January 1, 1976.

9. In the case of rental costs paid to the lessor of an ongoing facility, the rental amounts must not be in excess of reasonable rental costs (see paragraph (5)(F)3.).

(G) Taxes.

1. Taxes levied on or incurred by a provider shall be allowable costs with the exception of the following items:

A. Federal, state or local income and excess profit taxes including any penalties paid them;

B. Taxes, in connection with financing, refinancing or refunding operations such as taxes on the issuance of bonds, property transfer, issuance or transfer of stocks. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as a tax expense;

C. Taxes from which exemptions are available to the provider;

D. Special assessments on land which represent capital improvements such as sewers, water and pavements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid in annual installments;

E. Taxes on property which is not a part of the operation and sound conduct of the provider nor used in a normal standby or emergency capacity;

F. Taxes, such as sales taxes, which are levied against the recipient and collected and remitted by the provider; and

G. Self-employment Federal Insurance Contribution Act (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, to the extent these taxes exceed the amount which would have been paid by the provider on the allowable compensation of these persons had the provider organization been an incorporated rather than unincorporated entity.

(H) Issuance of Revenue Bonds and Tax Levies by District and County Facilities. Those nursing home districts and county

facilities whose funding is through the issuance of revenue bonds, in accordance with sections 198.312 and 205.371—205.375, RSMo will be granted as an allowable cost that interest which is paid per the revenue bonds; depreciation on the plant and equipment of these facilities shall also be an allowable cost. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset, except to the extent that the funds are used for the actual operation of the facility.

(I) Value of Services of Employees.

1. The value of services performed by employees in the facility shall be included in allowable costs to the extent actually compensated, either to the employee directly or to the supplying organization.

2. Services rendered *gratis* by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations, shall not be included in allowable costs, as these services traditionally have been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost provided that the services are not of a religious nature. An example of an allowable cost under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.

(J) Fringe Benefits.

1. Life insurance.

A. Types of insurance which are not considered an allowable cost—premiums related to insurance on the lives of officers and key employees are not allowable costs under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where, insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction and, upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit

against the loan balance. In this case, the provider is an indirect beneficiary. Insurance of this type is referred to as credit-life insurance.

B. Types of insurance which are considered an allowable cost where—

(I) Credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) The relative(s) or estate of the employee is the beneficiary. This type of insurance is considered to be compensation to the employee as a fringe benefit and is an allowable cost to the extent that the amount of coverage is reasonable.

2. Retirement plans.

A. Contributions to retirement plans for the benefit of employees, including owner employees of the provider, shall be allowable costs provided these plans meet the qualifications established in Section 401 of the *Internal Revenue Code* of 1954, as amended in the requirements for Title XVIII. These requirements state that—“A trust created or organized in the United States and forming parts of a stock bonus, pension or profit-sharing plan of an employer for the exclusive benefits of his/her employees or their beneficiaries shall constitute a qualified trust under this section if the contributions or the benefits provided under the plan do not discriminate in favor of employees who are—1) officers; 2) shareholders; or 3) highly compensated.” Interest income from funded pension or retirement plans shall be excluded from consideration in determining the allowable costs.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due or as anticipated and offset to expenses on the cost report form.

3. Deferred compensation plans.

A. Contributions for the benefit of employees, including owner employees under deferred compensation plans, shall be allowable costs when and to the extent that these costs are actually incurred and met by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost only when paid to the participating employee and only to the extent considered reasonable.

B. Amount paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually incurred and met by the provider.

C. Amounts funded to deferred compensation plans together with associated

income shall be recaptured if not actually paid when due or as anticipated and offset to expenses on the cost report form.

(K) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care of administration of the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is allowable only when specifically authorized in advance by the department.

2. Costs of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals.

(L) Organizational Costs.

1. Organizational costs may be included in allowable costs on an amortized basis.

2. Organizational costs include, but are not limited to, the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stock holders; and fees paid to states for incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off these costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five (5)-year period prior to his/her entry into the program and properly has capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance, the unamortized portion of organizational costs is allowable under the program and shall be amortized over the remaining part of the sixty (60)-month period.

(M) Advertising Costs. Advertising costs which are reasonable, appropriate and helpful in developing, maintaining and furnishing the provider services shall be allowable costs. These costs must be common and accepted occurrences in the field of the activity of the provider.

(N) Costs of Related Organizations.

1. Purchase from related organization(s). Costs applicable to services, facilities and supplies furnished to a provider by organization(s) related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the prices of comparable services, facili-

ties or supplies purchased elsewhere. The provider shall be required to identify the related organization(s) and costs to the related organization(s) in the uniform cost report(s). For the purpose of this section, common ownership and control will be determined by paragraphs (5)(N)2. and 3. of this rule.

2. Related to the provider means the following:

A. With respect to a partnership, each partner;

B. With respect to a limited partnership, the general partner and each limited partner with an interest of five percent (5%) or more in the limited partnership;

C. With respect to a corporation, each person who owns, holds or has the power to vote five percent (5%) or more of any class of securities issued by the corporation and each officer and director; and

D. With respect to a natural person, any parent, child, sibling or spouse of that person.

3. For the purposes of this section only, owner of a facility refers to any person who owns an interest of five percent (5%) or more in the following:

A. The land on which any facility is located;

B. The structure(s) in which any facility is located;

C. Any mortgage, contract for deed or other obligation secured in whole or part by the land or structure in or on which any facility is located; or

D. Any lease or sublease of the land or structure in or on which a facility is located. Owner does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly or through a subsidiary operates a facility.

(O) Utilization Review. Incurred cost for the performance of required utilization review for SNF, ICF, ICF/MR or SNF/ICF combination is an allowable cost. These expenditures must be for the purpose of providing utilization review on behalf of Title XIX recipients. Utilization review costs incurred for Title XVIII and XIX must be apportioned on the basis of recipient days recorded for each program during the reporting period.

(6) Upper Limits.

(A) In no event may the total reimbursement of a provider exceed the lesser of—

1. The current customary charges by the facility to the general public for the same services rendered to the Medicaid recipients

except in the case of public facilities rendering services at a nominal charge; these charges will be determined by the standard set forth in the *Medicare Provider Reimbursement Manual* (HIM-15), Part I, Section 2600;

2. The Title XVIII rates applicable; and

3. One hundred twenty-five percent (125%) of the weighted mean rate paid for each level-of-care group as follows: SNF, ICF, ICF/MR and SNF/ICF combination.

(B) The determination of weighted mean per-diem rates by level-of-care shall be determined and updated quarterly using reimbursement rates in effect the first day of that quarter.

(C) Providers shall be considered as similar facilities when classed by the following levels of care: ICF/MR or SNF, ICF, SNF/ICF combination.

(D) All costs in excess of the ceiling imposed shall not be carried forward.

(7) Minimum Utilization.

(A) In the event that the occupancy utilization of a provider in a cost-reporting period falls below ninety percent (90%) of its certified bed capacity, appropriate adjustments shall be made to the allowable costs of the provider. Fixed costs will be calculated as if the provider experienced ninety percent (90%) utilization. The fixed costs are laundry, housekeeping, administrative and general costs. Variable costs will be calculated at actual utilization. The variable costs are nursing, dietary and ancillary costs.

(B) In the event a provider's total reimbursement is reduced below allowable costs due to the limitation in subsection (7)(A), the unreimbursed allowable cost shall be subject to subsection (7)(C) and, if no waiver is granted, the retroactive adjustment shall be the lower of the actual cost or cost established under the provisions of subsection (7)(A).

(C) Subsections (7)(A) and (B) shall be waived for newly constructed facilities, new additions, or both, until an occupancy level of ninety percent (90%) is reached, but that waiver shall not exceed twelve (12) months from the date of licensure. A second waiver may be granted for an additional twelve (12)-month period. Subsections (7)(A) and (B) also will be waived for any facility which is closed completely for six (6) months or more and whose residents are removed, if and when this facility reopens.

(8) Nonreimbursable Costs.

(A) Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included in allowable costs.

(B) Those services that are specifically listed as provided in section 208.152, RSMo are attributable to Medicare and Medicaid and should be billed to those agencies.

(C) Any costs incurred that are related to fund drives are not reimbursable.

(D) Costs incurred for research purposes shall not be included as allowable costs.

(E) The cost of services provided under contract or subcontract under the Title XX program is specifically excluded as allowable costs.

(9) Other Revenues.

(A) Other revenues including, but not limited to those listed as follows, will be deducted from the total allowable cost, if included in gross revenue: income from telephone service; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time and other discounts, purchase rebates and refunds; recovery on insured loss; parking lot revenues; hospital room reservation charges; vendor machine commission; sales from drugs to other than recipients; sales from medical and surgical supplies to other than recipients; and room reservation charges in excess of two (2) days per quarter.

(B) Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided the interest is applied to the replacement of the asset being depreciated. Interest income other than from funded depreciation in excess of interest expense will not be used to offset other allowable costs.

(C) Cost centers or operations specified by the provider as subsection (10)(D) shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

(D) Restricted and Unrestricted Funds.

1. Restricted funds, as used in this rule, mean those funds, cash or otherwise, and including grants, gifts, taxes and income from endowments, which must be used only for a specific purpose designated by the donor. Those restricted funds which are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to restrict restricted funds designated by the donor for paying operating costs, these funds will not be offset from total allowable expenses.

2. Unrestricted funds, as used in this rule, mean those funds, cash or otherwise, and including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as

to their use. These funds can be used in any manner desired by the provider. However, those unrestricted funds which are not transferred funds and are used for paying operating costs will be offset from total allowable expenses.

3. Transferred funds, as used in this rule, are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local governmental provider. The transfer can be state-to-state, state-to-local or local-to-local providers. These funds are not considered a grant or gift for reimbursement purposes, so have no effect on the provider's allowable cost under this plan.

(10) Gains and Losses on Sales of Fixed Assets.

(A) Gains and losses on the sale or other disposition of buildings, furniture and equipment of a provider shall be taken into account in the determination of allowable costs only to the extent that the following provisions are applicable.

(B) There shall be a recapture of any subsection (10)(A) gain or loss according to the following ratio:

1. The numerator shall be the number of years during the asset life after July 1, 1976, that the provider has been reimbursed for all allowable costs by the Department of Social Services for Title XIX services. For the purposes stated here, the year in which the asset was purchased shall be included but the year in which the asset disposition is made will not be considered;

2. The denominator shall be the number of years the asset was owned and used in the operation of Title XIX facility; and

3. The ratio shall not exceed one hundred percent (100%).

(C) There shall be no recapture of any subsection (10)(A) gain or loss, in accordance with subsection (10)(B), unless subsection (10)(A) gain or loss, exceeds one thousand dollars (\$1000).

(D) The provider may designate specific assets or operations with the submission of each cost report that are not to be considered as relating to the nursing facility operation. The gains or losses from the sales of these assets or operations shall not be subject to subsections (10)(A)—(C).

(E) The provisions of subsections (10)(A)—(C) shall not apply to the dispositions of whole nursing facilities or similar changes of ownership.

(11) Apportionment of Costs to Medicaid Recipients.

(A) A provider's allowable costs shall be apportioned between Medicaid program recipients and other patients so that the share borne by the Medicaid program is based upon actual services received by program recipients.

(B) To accomplish this apportionment, the ratio of recipient's charges to total patient charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for program recipients determined on the basis of a separate average cost per diem for general routine care areas or, at the option of the provider, on the basis of the overall routine care area.

(C) So that its charges may be allowable for use in apportioning costs under the program, each provider should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing these services.

(D) Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

(E) A patient day of care is that period of service rendered a patient between the census taking hours on two (2) successive days, the day of discharge being counted only when the patient was admitted that same day. A census log shall be maintained in the facility for documentation purposes.

(F) Nursing facilities that provide skilled or intermediate nursing care, or both, to Medicaid recipients may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share common services and facilities as management services, dietary, housekeeping, building maintenance and laundry.

(G) Reimbursement is to be limited to the lower of the level-of-care required by the recipient or the level-of-care provided in the distinct part to which the recipient is assigned if admitted in accordance with 42 CFR 456.600-456.614.

(H) In no case may a provider's allowable costs allocated to the Medicaid program include the cost of furnishing services to persons not covered under the Medicaid program.

#### (12) Accounting Basis.

(A) The cost report submitted must be based on the accrual basis of accounting.

(B) Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods provided appropriate treatment of capital expenditures is made.

#### (13) Audits.

(A) Cost reports submitted shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

(B) If the provider has included the cost of a certified audit of the facility as a covered expense to this plan, a copy of that audit report and accompanying management letter shall be submitted without deletions.

(C) The annual cost report for the fiscal year of the provider shall be subject to audit by the Department of Social Services or their contracted agents. An audit guide will be prepared specifying the audit standards to be employed by the department.

(D) The department will conduct a desk review of all cost reports within four (4) months after submission by the provider and shall provide for on-site audits of facilities wherever cost variances or exceptions are noted by their personnel.

(E) No less than one-third (1/3) of the participating LTC facilities are to be audited each year over a three (3)-year period starting with the close of the cost reporting years beginning on or after January 1, 1977. These audits will be scheduled in a manner as to ensure that, at the close of this three (3)-year period, each participating LTC facility will have been audited.

(F) The department shall retain the annual cost report and any working paper relating to audits of the cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

(G) In accordance with the provisions of 42 CFR 447.295, a report of each on-site audit shall be submitted to the director of the Department of Social Services.

(H) In accordance with the provisions of 42 CFR 447.293, on-site audits will be performed each year after the initial three (3)-year period in at least fifteen percent (15%) of the participating facilities. At least five percent (5%) of the participating facilities shall be selected on a random basis and the remainder on the basis of exceptional profiles.

(I) Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%), an annual Title XIX payment of two hundred

thousand dollars (\$200,000) or more, or both, shall be required for at least the first two (2) fiscal years of participation in the plan to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. The Department of Social Services will accept a qualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the nursing home facility.

#### (14) Return on Equity.

(A) A return on a provider's net equity shall be paid as a part of the interim per-diem rate in addition to allowable costs.

(B) The amount of return on a provider's net equity shall initially be twelve percent (12%) for the state's fiscal year period 1976-1977; a new rate of return shall be established by the Department of Social Services each year thereafter prior to October 1 of that year. This rate shall be published yearly and, upon publication, shall be incorporated into this plan.

(C) For the purposes of this paragraph, owner's net equity is defined according to the *Medicare Provider Reimbursement Manual* (HIM-15), Section 1202.

(D) The return on owner's net equity shall be payable only to proprietary providers.

(E) A provider's return on owner's net equity shall be apportioned to the Medicaid program on the basis of the provider's Medicaid program days of care to total recipient days of care during the cost reporting period. For the purpose of this calculation, total recipient days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy rate during the cost year.

(15) Allowance for Known Cost Changes. A provider, at its election, may include with any regularly filed cost report, as an integral part of the report, a statement of known cost changes which reasonably can be anticipated to change the allowable costs of the subsequent cost-reporting period and which fall within guidelines as established by the department. Based upon this information, the provider may obtain an increase in its interim rate to cover the increases, provided adequate documentation is submitted with the report regarding the nature and amount of cost increases and their anticipated effect upon allowable costs in the subsequent reporting period.



(16) Inflationary Adjustments. Inflationary adjustments will be considered in calculating the interim per-diem rate. They will be based upon the past fiscal year and will be adjusted according to an index such as the *Composite Consumer Price Index (CPI)*. Rental, interest, depreciation expenses and property taxes will be excluded from the adjustments.

(17) Interim Rate.

(A) Each participating provider shall be assigned an interim per-diem rate for reimbursement under the Medicaid program which will be based principally upon the cost report of the facility for the preceding reporting period. Interim rates shall be established based upon the date in the cost report, adjusted as described in this rule and subject to further adjustment later by reason of audit changes to the cost report.

(B) A provider's interim rate for a given period shall take into account its past allowable costs and return on owner's net equity, all as most recently determined, together with an allowance for known cost increases.

(C) Upon initial entry into the Medicaid program after July 1, 1976, a provider not having had a full year of prior operation may submit budgetary projections of allowable costs to the department for the purpose of establishing an initial Medicaid interim rate. These budgetary projections shall be taken into consideration and included in the initial interim per-diem rate to the extent they do not exceed one hundred twenty-five percent (125%) of the weighted mean rate as determined by section (6). A new facility must operate at the initial rate for at least six (6) months.

(D) The budgetary projections shall be based upon a minimum occupancy utilization of ninety percent (90%) pursuant to the principles established in section (7).

(E) In the case of a change of ownership of an ongoing facility already participating in the Medicaid program, the rates in effect at the time of the change in ownership shall continue until new interim cost reports are submitted by the new owner in accordance with paragraph (4)(C)1. or 2.

(F) Approved interim rates shall become effective on or before the first day of the third month following the filing of any cost report as described in this rule.

(G) A written notification indicating the SNF, ICF, ICF/MR and SNF/ICF combination per-diem rates respectively will be transmitted to the facility upon approval by the director, Department of Social Services or his/her designee.

(H) In the event either party determines that a significant error or omission has been

made in the determination of the per-diem rate, this will be reported within thirty (30) days. Upon proper analysis of the problem, the Department of Social Services will be authorized to make adjustments consistent with the principles set forth in this rule and shall notify the provider in writing of its decision. In the event the decision is not acceptable, the provider has the right to appeal within sixty (60) days as provided under this plan, section (20).

(18) Retroactive Adjustments. Initial retroactive adjustments for each year payable to the provider and made in accordance with this plan shall be paid as soon as practicable within one hundred eighty (180) days after receipt of the provider's fiscal year cost report.

(19) Amounts Due the Department of Social Services for a Provider

(A) When there is an amount due the Department of Social Services from a provider, the single state agency shall notify the provider or the provider's representative of the amount of the overpayment. When a provider receives notice of an overpayment and the amount due is in excess of one thousand dollars (\$1000), the provider, within twenty (20) days of the notice, shall submit a plan for repayment to the single state agency which shall not exceed six (6) months in duration and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. If an alternative repayment plan is received timely from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case, and reject, accept or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within fifteen (15) days after the proposal is received. If no alternative plan for repayment is agreed upon within forty-five (45) days after the provider received notice of the overpayment, the withholding of payments to the provider shall commence as if no alternative plan for repayment had been submitted. Overpayments of one thousand dollars (\$1000) or less shall be repaid within forty-five (45) days.

(B) If a plan for repayment of amounts due the Department of Social Services from a provider is breached, discontinued or otherwise violated by a provider, the single state agency, immediately upon the next payment to the provider, shall begin to withhold payments or portions of payments until the entire amount due has been collected.

(C) If a provider fails or refuses to comply with the provisions of this rule, the single

state agency, at its discretion, may withhold funds from amounts due the provider in amounts as to guarantee full recovery of an overpayment over a period of time as the single state agency deems warranted under the circumstances.

(D) Repayment or an agreement to repay amounts due the Department of Social Services by a provider shall not prevent the imposition of any sanction by the single state agency upon the provider.

(E) The Department of Social Services shall account to HHS for the amounts on Form HCFA-64 (see 10 CSR 70-10.010) owed by providers no later than the second quarter following the quarter in which the overpayment was determined in accordance with principles of the plan.

(20) Appeals. Unresolved provider disputes involving an amount in excess of five hundred dollars (\$500) may be appealed to the Administrative Hearing Commission under the provisions of sections 161.274 and 208.156, RSMo and the corresponding rules established by the commission.

**APPENDIX  
Routine Covered Medical Supplies  
and Services**

- ABD Pads
- A & D Ointment
- Adhesive Tape
- Air Mattresses
- Air P.R. Mattresses
- Airway Oral
- Alcohol
- Alcohol Plasters
- Alcohol Sponges
- Antacid Suspensions
- Antipruritic Oil
- Applicators, Cotton-Tipped
- Applicators, Swab-Eez
- Aquamatic K Pads (water-heated pad)
- Arm Slings
- Asepto Syringes
- Baby Powder
- Bandages
- Bandages Elastic or Cohesive
- Bandaids
- Basins
- Bed Frame Equipment (for certain immobilized bed patients)
- Bed Rails
- Bedpan, Fracture
- Bedpan, Regular
- Bedside, Tissues
- Benzoin
- Bibs
- Bottle, Specimen
- Canes

Cannula—Nasal  
 Cascara (1 oz.)  
 Catheter, Indwelling  
 Catheter Plugs  
 Catheter Tray  
 Catheters (any size)  
 Colostomy Bags  
 Composite Pads  
 Cotton Balls  
 Crutches  
 Customized Crutches, Canes and Wheelchairs  
 Decubitus Ulcer Pads  
 Deodorants  
 Disposable Underpads  
 Donuts  
 Douche Bags  
 Drain Tubing  
 Drainage Bags  
 Drainage Sets  
 Drainage Tubes  
 Dressing Tray  
 Dressings (all)  
 Drugs, Nonlegend  
 Drugs, Stock (excluding Insulin)  
 Enema Can  
 Enema—Fleets  
 Enema—Retention  
 Enema Soap  
 Enema Supplies  
 Enema Unit  
 Enemas  
 Equipment and Supplies for Diabetic Urine Testing  
 Eye Pads  
 Feeding Tubes  
 Female Urinal  
 Flotation Mattress or Biowave Mattress  
 Flotation Pads, Turning Frames, or Both  
 Folding Foot Cradle  
 Gastric Feeding Unit  
 Gauze Sponges  
 Gloves, Unsterile and Sterile  
 Gowns, Hospital  
 Green Soap  
 Hand-Feeding  
 Heat Cradle  
 Heating Pads  
 Heel Protector  
 Hot Pack Machine  
 Ice Bags  
 Incontinency Care  
 Incontinency Pads and Pants  
 Infusion Arm Boards  
 Inhalation Therapy Supplies  
   Aerosol Inhalators, Self-Contained  
   Aerosol (other types)  
   Nasal Catheter Insertion and Tube  
   Nebulizer and Replacement Kit  
   Steam Vaporizer  
 Intermittent Positive Pressure Breathing Machines (IPPB)

Invalid Ring  
 Irrigation Bulbs  
 Irrigation Trays  
 I.V. Trays  
 Jelly—Lubricating  
 Kaolin and Pectin Solution  
 Linens, Extra  
 Lotion, Soap and Oil  
 Male Urinal  
 Massages (by nurses)  
 Medical Social Services  
 Medicine Cups  
 Medicine Dropper  
 Merthiolate Aerosol  
 Milk of Magnesia  
 Mineral Oil  
 Mouthwashes  
 Nasal Cannula  
 Nasal Catheter  
 Nasal Gastric Tubes  
 Nasal Tub Feeding  
 Needles (hypodermic, scalp, vein)  
 Needles (various sizes)  
 Nonallergic Tape  
 Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care  
 Nursing Supplies and Dressings (other than items of personal comfort or cosmetics)  
 Ointment (nonprescription, skin)  
 Overhead Trapeze Equipment  
 Oxygen  
 Oxygen Equipment (such as IPPB machines and oxygen tents)  
 Pads  
 Peroxide  
 Pharmaceuticals, Nonprescription  
 Pitcher  
 Plastic Bib  
 Pumps (aspiration and suction)  
 Restraints  
 Room and Board  
 Sand Bags  
 Scalpel  
 Sheepskin  
 Special Diets  
 Specimen Cups  
 Sponges  
 Sterile Pads  
 Stomach Tubes  
 Suction Catheter  
 Suction Machines  
 Suction Tube  
 Suppositories—Nonlegend  
 Surgical Dressings (including sterile sponges)  
 Surgical Pads  
 Surgical Tape  
 Suture Trays  
 Syringes, Disposable  
 Tape (for laboratory tests)  
 Tape (nonallergic or butterfly)

Testing Sets and Refills (S & A)  
 Tongue Depressors  
 Tracheostomy Sponges  
 Tray Service  
 Tubing—I.V. Trays, Blood Infusion Set, I.V. Tubing  
 Underpads  
 Urinary Drainage Tube  
 Urinary Tube and Bottle  
 Urological Solutions  
 Walkers  
 Water Pitchers  
 Wheelchairs

*AUTHORITY: section 207.020, RSMo Supp. 1993. \* This rule was previously filed as 13 CSR 40-81.080. Original rule filed Jan. 16, 1978, effective May 11, 1978. Emergency rescission filed Dec. 7, 1979, effective Dec. 31, 1979, expired March 12, 1980. Emergency rule filed Dec. 7, 1979, effective Jan. 1, 1980, expired March 12, 1980. Rescinded and readopted: Filed Dec. 7, 1979, effective May 11, 1980. Emergency amendment filed July 23, 1981, effective Aug. 1, 1981, expired Nov. 11, 1981. Amended: Filed July 23, 1981, effective Nov. 12, 1981. Emergency amendment filed Oct. 13, 1981, effective Oct. 23, 1981, expired Jan. 13, 1982. Amended: Filed Oct. 13, 1981, effective Jan. 14, 1982.*

*\*Original authority 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993.*

### 13 CSR 70-10.010 Prospective Reimbursement Plan for Long-Term Care

*PURPOSE: This rule establishes a payment plan for long-term care required by the **Code of Federal Regulations**. The plan describes principles to be followed by Title XIX long-term care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing the cost reports.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.*

(1) Authority. This rule is established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services to promulgate rules.

(2) Purpose. This rule establishes a methodology for determination of prospective per-diem rates for long-term care (LTC) facilities.

(3) General Principles.

(A) Provisions of this reimbursement plan shall apply only to facilities certified for participation in the Missouri Medical Assistance (Medicaid) program.

(B) The per-diem rates determined by this rule shall apply only to services provided on and after July 1, 1990.

(C) The effective date of this rule shall be July 1, 1990.

(D) The Medicaid program shall provide reimbursement for LTC services based solely on the individual Medicaid-eligible recipient's covered days of care (within benefit limitations) multiplied by the facility's Medicaid per-diem rate. No payments may be collected or retained in addition to the Medicaid per-diem rate for covered services. Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid per-diem rate shall be the lower of—

1. The Medicare (Title XVIII) per-diem rate, if applicable;

2. The per-diem rate as determined in accordance with section (11); or

3. The LTC ceiling (LTCC). The LTCC in effect on July 1, 1990, shall be a per-diem rate of fifty-four dollars and ninety-five cents (\$54.95). The LTCC will be increased by the amounts prescribed in paragraph (12)(A)1. effective for the dates of services and purposes specified in paragraph (12)(A)1.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A per-diem reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid program shall be assigned a provider number by the Division of Medical Services. Facilities previously certified shall retain the same provider number regardless of any change in ownership.

(H) Regardless of changes in ownership for any facility certified for participation in the Medicaid program, the division will issue allowable reimbursements to the facility identified in the current Medicaid participation agreement and will recover from that entity

liabilities, sanctions and penalties pertaining to the Medicaid program.

(I) A facility with certified and noncertified beds shall allocate allowable costs related to the provisions of LTC services in an equitable manner. The methods for allocation must be supported by adequate accounting, statistical data, or both, necessary to evaluate the allocation method and its application.

(J) Any facility which is terminated from participation in the Medicare program also shall be terminated from participation in the state's Medicaid program on the same date as the Medicare determination.

(K) No restrictions nor limitations shall be placed on a recipient's right to select providers of his/her own choice.

(L) The average Medicaid rate paid shall not exceed the average private pay rate for the same period covered by the facility's Medicaid cost report. Any amount in excess will be subject to repayment, recoupment, or both.

(4) Definitions.

(A) Allowable cost. Those costs which are allowable for allocation to the Medicaid program based upon the principles established in this rule. The allowability of costs not addressed specifically in this rule shall be determined by the Division of Medical Services. This determination may be based upon criteria such as the *Medicare Provider Reimbursement Manual* (HIM-15) and section (7) of this rule.

(B) Average private pay rate. The usual and customary charge for non-Medicaid patients determined by dividing total non-Medicaid days of care into revenue net of contractual allowances from the same service that is included in the Medicaid per-diem rate, excluding negotiated payment methodologies with state or federal agencies such as the Veterans Administration and the Missouri Department of Mental Health.

(C) The Building Cost Calculator (formerly known as the *Dodge Construction Index*). The cost per square foot as published in *Calculator and Valuation Guide* for a convalescent/nursing home of good quality, masonry wall construction as of mid-year 1970 and adjusted by the general purpose Local Building Cost Multiplier as of the following date: 1) the date the original Certificate of Need (CON) or waiver was issued, 2) if a six (6)-month extension was granted, the date the first extension was granted, or 3) if the facility was constructed prior to October 1, 1980, the date will be October 1, 1980. The Local Building Cost Multipliers used to adjust costs shall be those established for Columbia, Kansas City and St. Louis. The multiplier to

be used in determining a facility's rate shall be the one established for the city geographically closest to the facility as determined by the straight line distance (not road miles) between the two (2) points, as determined from the latest Missouri official highway map furnished by the Missouri Highways and Transportation Department. *Calculator and Valuation Guide* is a publication of Calculator, Inc., 12251 Harbor Drive, Woodbridge, VA 22192.

(D) Change of ownership. A change in ownership, control, operation or leasehold interest by any form for any facility certified for participation in the Medicaid program at any time.

(E) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in subsection (10)(A) of this rule and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with the procedures prescribed by the division and on forms provided or prescribed, or both, by the division.

(F) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(G) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(H) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(I) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(J) Division of Aging. The division of the Department of Social Services responsible for survey, certification and licensure of LTC facilities.

(K) Entity. Any natural person, all corporations, business, partnership or something that exists as a discrete unit.

(L) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(M) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.

(N) Intermediate care facility (ICF). Prior to October 1, 1990, a facility certified to provide intermediate care under the Title XIX program.

(O) LTC facility. Prior to October 1, 1990, a facility certified to provide skilled nursing services under the Title XIX program (skilled nursing facility (SNF)), or a facility certified to provide intermediate care under the Title XIX program (ICF), or a facility certified to provide skilled nursing and intermediate care under the Title XIX program (SNF/ICF). On and after October 1, 1990, a nursing facility (NF).

(P) New facility. A newly-built LTC facility for which an approved CON or applicable waiver was obtained and which was newly completed and operational on or after July 1, 1990.

(Q) Nursing facility (NF). Effective October 1, 1990, SNFs, SNF/ICFs and ICFs participating in the Medicaid program all will be subject to state and federal laws or regulations for participation as an NF.

(R) Occupancy. A facility's total actual patient days divided by the total bed days for the same period.

(S) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. Patient day includes the allowable temporary leave-of-absence days per subsection (5)(D). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(T) Provider or facility. An LTC facility with a valid Medicaid participation agreement in effect on or after July 1, 1990, with the Department of Social Services for the purpose of providing LTC services to Title XIX-eligible recipients.

(U) Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity in which, through its activities, one (1) entity's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in those dealings;

2. An entity has an ownership or controlling interest in another entity and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking

firm or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in this rule, the following terms mean:

A. Indirect ownership/interest, an ownership/interest in an entity that has an ownership/interest in another entity. This term includes an ownership/interest in any entity that has an indirect ownership/interest in an entity;

B. Ownership/interest, the possession of equity in the capital, in the stock or in the profits of an entity;

C. Ownership or controlling interest, when an entity—

(I) Has an ownership/interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership/interest equal to five percent (5%) or more in an entity. The amount of indirect ownership/interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership/interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership; and

D. Relative, person related by blood, adoption or marriage to the fourth degree of consanguinity.

(V) Restricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments which must be used only for a specific purpose designated by the donor.

(W) Skilled nursing facility (SNF). Prior to October 1, 1990, a facility certified to provide skilled nursing services under the Title XIX program.

(X) SNF/ICF combination. Prior to October 1, 1990, a facility certified to provide skilled nursing and intermediate care under the Title XIX program.

(Y) Square footage. The square footage of a facility will be determined from the records of the county assessor of the county where the facility is located. For facilities that are

exempt from property tax assessment, the square footage of the facility shall be determined from a certified statement from a licensed architect verifying the square footage of the facility in accordance with the American Institute of Architects Document D101.

(Z) Unrestricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments which are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the per-diem rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a per-diem rate but which also are billable to the Title XVIII Medicare program must be billed to that program for facilities participating in the Title XVIII Medicare program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and supplies required by federal or state law or regulation which must be provided by LTC facilities participating in the Title XIX program;

(B) Semiprivate room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, and the like;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days specifically must be provided for in the recipient's plan of care and physician prescribed. Periods of time during which a recipient is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of nursing services;

(F) Provision of personal hygiene and routine care services furnished routinely and relatively uniformly to all residents;

(G) All laundry services, including personal laundry;

(H) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(I) All consultative services required by federal or state law or regulation;

(J) All therapy services required by federal or state law or regulation;

(K) All routine care items, including disposables and including, but not limited to,

those items specified in Appendix A to this rule;

(L) All nursing care services and supplies, including disposables and including, but not limited to, those items specified in Appendix A to this rule;

(M) Any and all nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. Providers may not elect which nonlegend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's per-diem rate; and

(N) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Noncovered Supplies, Items and Services. All supplies, items and services which are not either covered in a facility's per-diem rate, billable to another program in the Missouri Medical Assistance (Medicaid) program or billable to Medicare or other third-party payors. Noncovered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection and loud irrational speech. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service and therefore a Medicaid recipient or responsible party may pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid per diem unless the recipient or responsible party, in writing, specifically requests a private room prior to placement in one and acknowledges that an additional amount not payable by Medicaid will be charged for it;

(B) Supplies, items and services for which payment is made under Missouri Medical Assistance (Medicaid) program directly to a provider(s) other than providers of the LTC services; and

(C) Supplies, items and services provided nonroutinely to residents for personal comfort or convenience.

(7) Allowable cost areas are—

(A) Compensation of owners.

1. Compensation of services of owners shall be an allowable cost area, provided the services are actually performed, are necessary and are reasonable.

2. Compensation shall mean the total benefit, within the limitations set forth in this rule, received by the owner for the services s/he renders to the facility, including direct

payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this rule. Compensation must be paid (whether in cash, negotiable instrument or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the *Medicare Provider Reimbursement Manual (PRM)*, Part 1, Section 906.4.

3. Reasonableness of compensation shall be limited as prescribed in subsection (8)(Q).

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility; had the owner not rendered these services, then employment of another entity to perform the service would be necessary;

(B) Covered services and supplies as defined in section (5) of this rule.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

A. The book value of the provider;

B. Fair market value at the time of acquisition;

C. The recognized Internal Revenue Service (IRS) tax basis; and

D. In the case of change in ownership after July 18, 1984, the cost basis of acquired assets of the owner of record as of July 18, 1984, as of the effective date of the change in ownership or, in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program.

4. The basis of donated assets will be allowed to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the division as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the Medicaid program and the facility in

ratio to Medicaid recipient reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the Medicaid program need not correspond to the method used by a provider for non-Medicaid purposes; however, useful life shall be in accordance with the *American Hospital Association's Guidelines*. Component part depreciation is optional and allowable under this rule.

6. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under GAAP. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. When a provider has elected, for federal income tax purposes, to expense certain items, such as interest and taxes during construction, the historical cost basis for Medicaid depreciation purposes may include the amount of these expensed items. However, when a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For purposes of this rule, any asset costing less than one thousand dollars (\$1000), or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as described in paragraph (7)(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the depreciation base if the capital expenditures fail to comply with any federal or state law or regulation, such as CON.

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this rule;

(D) Interest and finance costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for purposes such as working capital

for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions, or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. Interest (including finance charges, prepaid costs and discounts) must be supported by evidence of a written agreement that funds were borrowed and that payment of interest and repayment of the funds are required. The interest costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed and must be necessary and proper for the operation, maintenance or acquisition of the provider's facility.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the market at the time the loan was made.

7. Interest on loans to for-profit providers by proprietors, partners and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection (7)(C), the interest associated with the portion of the loan(s) which exceeds the asset cost basis as defined in subsection (7)(C) shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per-diem rate.

10. A provider shall amortize finance charges, prepaid interest and discounts over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs excluding finder's fees incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the period of the loan ratably or by means of the constant rate of interest method.

12. Usual and customary costs shall be limited to the lender's title and recording

fees, appraisal fees, legal fees, escrow fees and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a provider's bed capacity shall not be an allowable cost item if the capital expenditures fail to comply with any federal or state law or regulation, such as CON;

(E) Rental and leases.

1. Rental and leases of land, buildings, furnishings and equipment are allowable cost areas; provided, that the rented items are necessary and not, in essence, a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties which is subject to other provisions of this rule, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership after July 18, 1984, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or, in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program, shall be a nonallowable cost;

(F) Real estate and personal property taxes levied on or incurred by a facility.

(G) Issuance of revenue bond and tax levies by district and county facilities. For those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be granted as an allowable cost item. Depreciation on the plant and equipment of these facilities also shall be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a

revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of services of employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations shall not be an allowable cost, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost; provided, that the services are not of a religious nature. Building costs on space set aside primarily for professionals providing any religious function shall not be allowable. Costs for wardrobe and similar items likewise are considered nonallowable;

(I) Fringe benefits.

1. Retirement plans.

A. Contributions to qualified retirement plans for the benefit of employees, excluding stockholders, partners and proprietors of the provider shall be an allowable cost. Interest income from funded pension or qualified retirement plans shall be excluded from revenue offsets.

B. Amounts funded to pension and qualified retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

2. Deferred compensation plans.

A. Contributions for the benefit of employees, excluding stockholders, partners and proprietors, under deferred compensation plans shall be allowable costs when, and to the extent that, these costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered an allowable cost only when paid to the participating employee and only to the extent considered reasonable.

B. Amounts paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually

paid when due, as an offset to expenses on the cost report.

3. Types of insurance which are considered an allowable cost area.

A. Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs.

B. Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable;

(J) Education and training expenses.

1. Except for costs associated with nurse aide training, and competency evaluation programs after October 1, 1990, the cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost only when specifically authorized in advance in writing by the division.

2. Costs of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals;

(K) Organizational costs.

1. Organizational costs may be included as an allowable cost, if properly amortized.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. When a provider did not capitalize organizational costs and has written off those costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five (5)-year period prior to entry into the program and has properly capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty (60)-month period.

6. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost;

(L) Advertising costs. Advertising costs which are reasonable and appropriate. The costs must be a common and accepted occurrence for providing LTC services.

(M) Cost of supplies and services involving related parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the uniform cost report, a provider shall identify related party suppliers and the type, the quantity and costs to the related party for goods and services obtained from each supplier.

(N) Utilization review. Costs incurred for the performance of required utilization review.

(O) Minimum utilization. In the event the occupancy rate of a facility is below ninety percent (90%), the following cost centers will be adjusted as though the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, plant operation and general and administrative. In no case may costs disallowed under this provision be carried forward to succeeding periods. Cost centers are expenses grouped in accordance with the headings as identified in the cost report.

(P) Return on equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall not exceed twelve percent (12%) per year.

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property and equipment (cost of land, mortgage payments toward principal and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital which is required to insure proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. A provider's return on owner's net equity shall be apportioned to the Medicaid program on the basis of the provider's Medicaid program reimbursable recipient resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost report year;

(Q) Capital.

1. Capital reimbursement will be determined as follows:

A. For facilities entering the program after July 1, 1990, allowable capital is as described in paragraph (7)(Q)2. except the movable equipment rate described in item (7)(Q)2.A.(I)(a)IV. shall be sixty-five cents (65¢) per bed day which equates to two hundred twenty dollars (\$220) per bed;

B. For facilities which entered the program after March 18, 1983, and which were not in operation for two (2) years prior to entering the program, allowable capital is as described in paragraph (7)(Q)2.;

C. For facilities which were in operation for two (2) years prior to entering the program and which entered the program between March 18, 1983 and prior to July 1, 1990, allowable capital shall be depreciation; rent or leases, or both; interest and finance costs; organizational costs; and return on equity as described in the provisions of this rule; and

D. For facilities which entered the program prior to March 18, 1983, allowable capital shall be depreciation; rent or leases, or both; interest and finance costs; organizational costs; and return on equity as described in the provisions of this rule.

2. In lieu of depreciation; rent or leases, or both; interest and finance costs; organizational costs; and return on equity as described in the provisions of this rule, allowable capital for facilities described in subparagraphs (7)(Q)1.A. and B. shall be the sum of the building and equipment rate, land rate and working capital rate determined in accordance with the following procedures:

A. The building and equipment rate will be computed in the following way:

(I) Determine the lower of—

(a) Dodge allowable for building and equipment, which is computed as—

I. Reasonable construction or acquisition cost computed by applying the Building Cost Calculator as defined in this rule for the facility geographically closest to St. Louis, Kansas City or Columbia, multiplied by one hundred eight percent (108%) as an allowance for fees authorized as architectural or legal not included in the Building Cost Calculator, multiplied by the square footage of the facility not to exceed three hundred twenty-five (325) square feet per bed;

II. Multiply by a return rate of twelve percent (12%);

III. Divide by ninety-three percent (93%) of the facility's total available beds multiplied by three hundred sixty-five (365) days; and

IV. Add fifty-three cents (53¢) per bed day to cover the movable equipment,

which equates to one hundred eighty dollars (\$180) per bed divided by the product of ninety-three percent (93%) multiplied by three hundred sixty-five (365) days; or

(b) Actual acquisition cost, which is computed as—

I. Actual acquisition cost, which is the original cost to construct or acquire the building, including fixed and movable equipment, and excluding land costs not to exceed the limitations on reimbursement as set forth in 13 CSR 70-10.100, if applicable;

II. Multiply by a return rate of twelve percent (12%);

III. Divide by ninety-three percent (93%) of the facility's total available beds multiplied by three hundred sixty-five (365) days;

B. The land rate.

(I) The maximum allowable land area is defined as five (5) acres for a facility with one hundred (100) or fewer beds and one (1) additional acre for each additional one hundred (100) beds or fraction of beds for a facility with one hundred one (101) or more beds.

(II) Calculation.

(a) For facilities with land areas at or below the maximum allowable land area, multiply the acquisition cost of the land not to exceed the limitations on reimbursement as set forth in 13 CSR 70-10.100, if applicable, by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds multiplied by three hundred sixty-five (365) days.

(b) For facilities with land areas greater than the maximum allowable land area, divide the acquisition cost of the land not to exceed the limitations on reimbursement as set forth in 13 CSR 70-10.100, if applicable, by the total acres, multiply by the maximum allowable land area, multiply by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds, multiplied by three hundred sixty-five (365) days;

C. The working capital rate will be twenty cents (20¢) per day. This amount was determined to be the average daily balance due to a facility for services provided to the state with a return rate of twelve percent (12%), divided by ninety-three percent (93%); and

D. If a provider does not provide the actual acquisition cost to determine the building and equipment rate and the land rate, the building and equipment rate will be computed using subpart (7)(Q)2.A.(I)(b), and the land rate will be zero cents (0<sup>00</sup>); and

(R) Central office, pooled costs, management company costs. The allowability of the individual cost items contained within central office, pooled costs or management company costs will be determined in accordance with all other provisions of this rule. The total of central office, pooled costs and management company costs, or a combination of these, are limited to seven percent (7%) of revenues.

(8) Nonallowable Costs. Cost not reasonably related to LTC facility services shall not be included in a provider's costs. Contractual allowances, courtesy discounts, charity allowances and similar adjustments or allowances are offsets to revenue and not included in allowable costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, purchased CON, but excluding organizational costs;

(B) Attorney fees related to litigation involving state, local or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators or administrators;

(C) Bad debts;

(D) Capital cost increases due solely to changes in ownership;

(E) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(F) Charitable contributions;

(G) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under sub-section (7)(A) of this rule;

(H) Costs such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(I) Directors' fees included on the cost report in excess of two hundred dollars (\$200) per month per individual;

(J) Federal, state or local income and excess profit taxes, including any interest and penalties paid on them;

(K) Late charges and penalties;

(L) Finder's fees;

(M) Fund-raising expenses;

(N) Interest expense on intangible assets;

(O) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(P) Noncovered supplies, services and items as defined in section (6);

(Q) Owner's compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated *Medicare PRM* Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. Owners/administrators will be adjusted on the basis of the high range; owners included in home office costs or management company costs will be adjusted on the high range provided the owner works a minimum of forty (40) hours a week in the home office, management company or owned nursing homes. All others will be calculated on the median range.

2. The salary identified in subparagraph (8)(Q)1.B. will be apportioned on the basis of hours worked in the facility(ies), home office or management company as applicable to total hours reported for all business interests. A forty (40)-hour minimum will be applied if total hours for all business interests are less than forty (40) hours;

(R) Prescription drugs;

(S) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(T) Research costs;

(U) Resident personal purchases;

(V) Salaries, wages or fees paid to non-working officers, employees or consultants;

(W) Stockholder relations or stock proxy expenses;

(X) Taxes or assessments for which exemptions are available;

(Y) Value of services (imputed or actual) rendered by nonpaid workers or volunteers; and

(Z) All costs associated with nurse aide training and competency evaluation programs after October 1, 1990.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report if included in gross revenues. These revenues include, but are not limited to, the following:

1. Income from telephone services;
2. Sale of employee and guest meals;
3. Sale of medical abstracts;



- 4. Sale of scrap and waste food or materials;
- 5. Rental income;
- 6. Cash, trade, quantity, time and other discounts;
- 7. Purchase rebates and refunds;
- 8. Recovery on insured loss;
- 9. Parking lot revenues;
- 10. Vending machine commissions or profits;
- 11. Sales from drugs to individuals other than Medicaid recipients;
- 12. Interest income to the extent of interest expense;
- 13. Noninterest income from investments;
- 14. Room reservation charges other than covered therapeutic home leave days;
- 15. Barber and beauty shop revenue;
- 16. Private room differential;
- 17. Medicare Part B revenues;
- 18. Personal services;
- 19. Activity income; and
- 20. Revenue recorded for donated services and commodities.

(B) Interest income received from a funded depreciation account will not be deducted from allowable operating costs if that interest is applied to the asset being depreciated.

(C) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(D) Restricted funds designated by the donor for future capital expenditures will not be offset from allowable expenses at any time.

(E) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(F) As applicable, restricted and unrestricted funds will be offset in each cost center, excluding capital costs, in an amount equal to cost center's proportionate share of allowable expense.

(G) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(10) Provider Reporting and Recordkeeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12)-month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division of Medical Services an Annual Cost Report, Financial and Statistical Report for Nursing Facilities,

including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this rule.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment under GAAP of capital expenditures is made.

5. Cost reports shall be submitted by the first day of the fourth month following the close of the fiscal period.

6. If requested in writing, one (1) thirty (30)-day extension of the filing date may be granted.

7. If a cost report is more than ten (10) days past due, payment will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's Medicaid participation and retain all payments which have been withheld pursuant to this provision.

8. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, within fifteen (15) days of filing the returns;

G. Leases, rental agreements, or both, related to the activities of the provider;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

9. Cost reports must be fully, clearly and accurately completed and all required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the division or its authorized agent is not provided within fourteen (14) days of the provider's receipt of the request, payments may be withheld from the facility until the information is submitted.

10. Under no circumstances will the division accept amended cost reports for rate determination or rate adjustment after the date of the division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of authorization shall be furnished upon request.

2. Cost reports must be notarized by a licensed notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine, imprisonment, or both, under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by

\_\_\_\_\_  
(Provider name(s) and number(s))  
for the cost report period beginning

\_\_\_\_\_, 19\_\_\_\_ and ending

\_\_\_\_\_, 19\_\_\_\_, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the

provider in accordance with applicable instructions, except as noted.

\_\_\_\_\_  
(Signature) (Title) (Date)

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be maintained separately with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

4. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the program shall be required to have an annual audit of the financial records used to prepare annual cost reports covering, at a minimum the first two (2) full twelve (12)-month fiscal years of their participation in the Medicaid program. For example: A provider begins business in March, they choose a fiscal year of October 1 to September 30, their first cost report will cover March through September.

That cost report may be audited at the option of the provider. The October 1 to September 30 cost report (the first full fiscal year cost report) shall be audited and the next October 1 to September 30 cost report shall be audited. The audits shall be done by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmation of accounts receivable and accounts payable are not required by the plan.

(E) Change in Provider Status.

1. Upon termination of participation in the Medicaid program or change of ownership, the provider is required to submit a cost report for the period ending with the date of termination or change, regardless of its tax period. The fully completed cost report with all required attachments and documentation is due within forty-five (45) days after the date of termination or change.

2. The next payment due the provider after the division has received the notification of the termination or change may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the LTC facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity(ies) that owns, controls or manages one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Allocation of central office or pooled costs to individual facilities shall be consistent from year-to-year. If a desk review or field audit established that records are not maintained so as to clearly identify information required by this rule, those commingled costs shall not be recognized as allowable cost in determining the facility's Medicaid per-diem rate. Allowability of these costs shall be determined in accordance with the provisions of this rule.

(11) Rate Determination. Subject to limitations prescribed elsewhere in these rules, a facility's per-diem rate shall be determined by the division as described in this section.

(A) A facility with a valid Medicaid participation agreement in effect on June 30, 1990, and with a cost report on file with the division as of December 31, 1989, with a period ending in calendar year 1988 shall be

granted a prospective per-diem rate effective for service dates on and after July 1, 1990. This rate will be the greater of the amount determined in the following paragraphs:

1. The allowable cost per patient day as determined by the division from the desk-reviewed or field-audited cost report, or both, with a period ending in calendar year 1988 will be multiplied by one hundred eleven and one-tenth percent (111.1%). One dollar and six cents (\$1.06) will be added to this adjusted cost per patient day amount to allow for the April 1, 1990 change in the minimum wage and the total will be subject to and limited by the ceiling amount of fifty-four dollars and ninety-five cents (\$54.95). The division will use a cost report which has an ending date in calendar year 1988 which is on file with the division as of December 31, 1989, and no amended information will be accepted after that date. If a facility has more than one (1) cost report with periods ending in calendar year 1988, the report covering a full twelve (12)-month period ending in calendar year 1988 will be used. If none of the reports covers twelve (12) months, the report with the latest period ending in calendar year 1988 will be used; or

2. The per-diem rate in effect for services rendered on June 30, 1990.

(B) A facility with a valid Medicaid participation agreement in effect on June 30, 1990, which does not have a cost report with a period ending in calendar year 1988 shall be granted an interim per-diem rate effective for service dates on and after July 1, 1990, equal to the per-diem rate in effect for services rendered on June 30, 1990. A prospective per-diem rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk-reviewed, field-audited, or both, facility fiscal year cost report which covers either the first twelve (12) months of operation under rules applicable at the time the facility entered the Medicaid program or the second twelve (12)-month fiscal year following the initial date of Medicaid certification. The facility must elect the option in writing and it must be received by the Division of Medical Services no later than October 1, 1990. A facility failing to notify the Division of Medical Services of its intent shall have its prospective per-diem rate established on the basis of the second twelve (12)-month facility fiscal year following the initial date of Medicaid certification. This prospective per-diem rate shall be retroactively effective for services beginning on the first day of the facility's option year but not earlier than July

1, 1990, and shall replace the interim per-diem rate on and after that date. Rate adjustment per paragraph (12)(A)1. which may have been granted for service dates on and after the effective date of the prospective per-diem rate will be applied when effective.

(C) Except as provided in subsection (11)(D), a facility entering the Medicaid program after June 30, 1990, shall receive an interim per-diem rate equal to ninety-five percent (95%) of the LTCC in effect on the initial date of Medicaid certification to be effective for services rendered on and after the initial date of Medicaid certification. A prospective per-diem rate will be determined on the basis of the division's determination of the allowable cost per patient day as determined by the division from the desk-reviewed, field-audited, or both, facility fiscal year cost report which covers the second twelve (12)-month fiscal year following the facility's initial date of Medicaid certification for new facilities, and the first twelve (12)-month fiscal year cost report for facilities entering the Medicaid program after June 30, 1990, which are not new facilities. This prospective per-diem rate shall be effective retroactively for services beginning on the first day of the new facility's second twelve (12)-month fiscal year and the first day of the facility's first twelve (12)-month fiscal year for facilities entering the Medicaid program after June 30, 1990, which are not new facilities and shall replace the interim per-diem rate on and after that date. Rate adjustment per paragraph (12)(A)1. which may have been granted for service dates on and after the effective date of the prospective per-diem rate will be applied when effective.

(D) A facility with a valid Medicaid participation agreement in effect on or after July 1, 1990, which either voluntarily or involuntarily terminates its participation in the Medicaid program and which reenters the Medicaid program shall have its prospective per-diem rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to reentry into the program as described in paragraph (12)(A)1. This prospective per-diem rate shall be effective for service dates on and after the effective date of the reentry following a voluntary or involuntary termination.

(12) Adjustments to the Per-Diem Rate. Subject to the limitations prescribed elsewhere in these rules, a facility's per-diem rate may be adjusted as described in this section.

(A) Adjustments determined by the division without the advice of the rate advisory committee.

1. Global per-diem rate adjustments. Global per-diem rate adjustments shall be added to the LTCC. All facilities with valid Medicaid participation agreements in effect on the effective date of the adjustments shall be eligible for the global per-diem rate adjustments. A facility with either an interim rate or a prospective per-diem rate may qualify for the global per-diem rate adjustments as follows:

A. Laundry. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on July 1, 1990, per subsections (11)(A) and (B) shall be granted an increase to their per-diem rate effective July 1, 1990, of fifty cents (50¢) per patient day related to personal laundry;

B. Negotiated trend factor. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on July 1, 1990, per subsections (11)(A) and (B) shall be granted an increase to their per-diem rate effective July 1, 1990, of forty-seven cents (47¢) per patient day for the negotiated trend factor. This amount is one percent (1%) of the average per-diem rate paid to all facilities on April 30, 1990;

C. Minimum wage adjustment. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on April 1, 1991, per subsections (11)(A) (C) shall be granted an increase to their per diem of one dollar and six cents (\$1.06) effective April 1, 1991, to allow for the April 1, 1991 change in minimum wage. This amount is two and one-tenth percent (2.1%) of the weighted average per-diem rate paid to all facilities on February 28, 1991;

D. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per-diem rate in effect on July 1, 1992, shall be granted an increase to their per-diem rate effective July 1, 1992, of three dollars and ninety-six cents (\$3.96) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the weighted average per-diem rate of fifty-two dollars and eighty-two cents (\$52.82) for January 1992;

E. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per-diem rate in effect on July 1, 1992, shall be granted an increase to their per-diem rates effective July 1, 1992, of seventy-four cents (74¢) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%)

of the weighted average per-diem rate of fifty-two dollars and eighty-two cents (\$52.82) for January 1992; and

F. Workers' Compensation. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on January 1, 1994, shall be granted an increase to their per-diem rate effective January 1, 1994, of thirty-eight cents (38¢) per patient day related to Workers' Compensation.

2. Special per-diem rate adjustments. Special per-diem rate adjustments shall not be added to the LTCC. Only those facilities qualifying for special per-diem rate adjustments are eligible for the special per-diem rate adjustments as follows:

A. Nursing home reform.

(I) ICFs. A facility certified for participation as an ICF as of June 30, 1990, or a facility certified after January 1, 1990, as an SNF which did not apply for a change-in-level-of-care adjustment as of June 30, 1990, may be granted the consultant adjustment described in subpart (12)(A)2.A.(I)(a) effective for service dates on and after July 1, 1990. A facility qualifying for the consultant adjustment must apply between July 1, 1990, and December 31, 1990, in order to be considered for or receive the registered nurse (RN) or the licensed practical nurse (LPN) adjustment, or both, described in subparts (12)(A)2.A.(I)(b) and (c), which will be effective beginning on the application date but no earlier than July 1, 1990, subject to applicable waivers. A facility must demonstrate by September 1, 1992, that they have hired the RNs and LPNs for which they have received an adjustment by submitting a consecutive two (2)-week staffing pattern between the effective date of the adjustment and May 1, 1992; and, to the extent that a facility does not demonstrate by that staffing pattern that it hired the RNs, LPNs, or both, for which it received an adjustment under subparts (12)(A)2.A.(I)(b) and (c), that facility's rate will be reduced by the undemonstrated portion of the adjustment, both retroactive to the effective date of the adjustment and prospectively, and the overpayment will be recouped. These are one (1)-time adjustments.

(a) Consultant adjustment. One dollar (\$1) will be added to the per-diem rate in effect on July 1, 1990, for qualifying facilities to allow for consultant requirements. This amount was derived from the 1988 SNF consultant costs converted to a weighted mean cost per patient day and then increased by twenty percent (20%).

(b) RN adjustment. An RN is required for eight (8) consecutive hours, seven (7) days a week. The RN requirement

will be compared to a facility's RN staffing as documented on the 1988 staffing reports (DOA 184) on file as of December 31, 1989, with the Division of Aging. If a facility does not have 1988 staffing reports, the latest report on file as of June 30, 1990, will be used. The difference between the daily RN requirement and the average daily RN staffing per the DOA 184s will be determined and multiplied by a per-hour rate of sixteen dollars and eighty-one cents (\$16.81) to arrive at total daily cost. The per-hour rate was derived from 1988 RN rates for ICFs, including fringe benefits at fifteen percent (15%) and then increased by twenty percent (20%). If the total daily cost is positive, it will be divided by average daily licensed occupied beds or ninety percent (90%) of licensed beds, whichever is greater to obtain the RN adjustment to the per-diem rate in effect on July 1, 1990. Occupancy data will be obtained from the fourth quarter 1989 occupancy statistics of the Division of Aging or the most recent data if fourth quarter 1989 occupancy statistics are not available for the facility.

(c) LPN adjustments. For a facility with average daily occupancy of sixty (60) or fewer residents, eight (8) hours of LPN coverage is required for each of two (2) eight (8)-hour shifts seven (7) days a week, except in cases when the RN requirement is waived. If the RN requirement is waived and the facility has average daily occupancy of sixty (60) or fewer residents, eight (8) hours of LPN coverage is required for each of three (3) eight (8)-hour shifts seven (7) days a week. For a facility with occupancy in excess of sixty (60) residents, eight (8) hours of LPN coverage is required for each of three (3) eight (8)-hour shifts seven (7) days a week. The LPN requirement will be compared to the facility's LPN staffing as documented on the 1988 staffing reports (DOA 184) on file as of December 31, 1989, with the Division of Aging. If a facility does not have 1988 staffing reports, the latest report on file as of June 30, 1990, will be used. The difference between the daily LPN requirement and the average daily LPN staffing per the DOA 184s will be determined and multiplied by a per-hour rate of ten dollars and eighty-three cents (\$10.83) to arrive at total daily cost. The per-hour rate was derived from 1988 LPN rates for ICFs, including fringe benefits at fifteen percent (15%) and then increased by twenty percent (20%). If the total daily cost is positive, it will be divided by average daily licensed occupied beds or ninety percent (90%) of licensed beds, whichever is greater to obtain the LPN adjustment to the per-diem rate in effect on July 1, 1990. Occupancy

data will be obtained from this fourth quarter 1989 occupancy statistics of the Division of Aging or the most recent data if fourth quarter 1989 occupancy statistics are not available for the facility; and

B. High volume provider. A facility must qualify each July 1 for the high volume adjustment. For a facility which has a high volume adjustment on June 30, 1994, and does not qualify July 1, 1994, that facility's prospective rate will be reduced by the amount of the high volume adjustment included in the facility's prospective per-diem rate in effect June 30, 1994. The adjustment will be effective for services rendered between July 1, 1994 through June 30, 1995. Effective with the state's Fiscal Year 1996, the division may reconstruct and redefine the qualifying criteria and payment methodology for the high volume adjustment.

(I) A facility must meet all four (4) of the following qualifications:

(a) A full twelve (12)-month cost report ending in calendar year 1992. For a nonprofit facility that changed ownership or operator, or both, and filed a partial year cost report, the latest period cost report will be considered as a full twelve (12)-month cost report;

(b) One hundred six and two-tenths percent (106.2%) of the allowable cost per patient day as determined by the division from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeds the LTCC in effect June 30, 1994, as identified in paragraph (3)(E)3.;

(c) Total occupied beds as determined from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeds eighty-five percent (85%) of licensed beds or facilities that had a high volume adjustment on June 30, 1994, and had total occupied beds as determined from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeding eighty-three percent (83%) of licensed beds. If the facility did not include all licensed beds on the cost report, this qualifier will be determined from the Division of Aging quarterly report of licensed occupancy for the 1992 quarter which ends on an ending date closest to the ending date of the cost report; and

(d) Medicaid-occupied beds as determined from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeds eighty percent (80%) of the total licensed occupied beds identified in subpart (12)(A)2.B.(I)(c) or provide at minimum sixty-five thousand (65,000) Missouri Medicaid patient days as determined from the cost report identified in subpart (12)(A)2.B.(I)(a).

(II) The adjustment will be equal to ten percent (10%) of the LTCC which was in

effect June 30, 1994. This amount was six dollars and twenty-one cents (\$6.21).

(III) If a facility qualifies for the high volume adjustment, their LTCC adjustment will be six dollars and twenty-one cents (\$6.21) above the LTCC in effect for services rendered between July 1, 1994 through June 30, 1995;

C. 1967 *Life Safety Code* (LSC). Currently certified LTC facilities that must comply with a recent interpretation of paragraph 10-133 of the 1967 LSC which requires corridor walls to extend to the roof deck or achieve equivalency under the Fire Safety Evaluation System (FSES) will be reimbursed the reasonable and necessary cost to meet those standards required for compliance through their Medicaid per-diem rate. The reimbursement shall not be effective until the Division of Aging has confirmed that the corrective action to comply with the 1967 LSC or FSES is operational. Fire sprinkler systems shall be reimbursed over a depreciation life of twenty-five (25) years and other alternative corrective action will be reimbursed over a depreciable life of fifteen (15) years. The nursing home's rate plus this adjustment will be limited to the Medicaid LTCC per subpart (12)(A)2.B.(I)(a). The division will use a cost report with the latest period ending in calendar year 1992 which is on file with the division as of July 1, 1993. This adjustment will be computed as follows based on the cost documented and submitted to the Division of Medical Services:

(I) Depreciation. The asset value for the actual cost incurred for the approved corrective action to continue in compliance divided by the depreciable useful life;

(II) Interest. The interest cost incurred to finance this project shall be documented by a statement from the lending institution detailing the total interest cost of the loan period. The total interest cost will be divided by the loan period; and

(III) The total of the result of depreciation and interest will be divided by twelve (12) and then multiplied by the number of months covered by the 1991 cost report. This amount will be divided by the greater of actual patient days from the 1991 cost report or ninety percent (90%) of the available bed days from the 1991 cost report;

D. Effective March 1, 1993, any nursing facility licensed under Chapter 198, RSMo and operated by a district or county which receives local tax revenues and certifies these revenues to the Department of Social Services shall receive an adjustment to their per-diem rate. The adjustment shall not exceed ninety percent (90%) of the Medicaid portion of the local tax revenues in aggregate

divided by the total projected Medicaid payments for FY-93 for those qualifying facilities. The adjustment will be limited by the class ceiling. Any unused certified local tax revenues will not carry forward into the next state fiscal year's calculation.

(I) The Medicaid portion is determined by multiplying the total local tax revenues certified to the Department of Social Services for each facility by each facility's Medicaid occupancy rate as reported on their 1990 cost report.

(II) The projected Medicaid payments for FY-93 are computed by multiplying the per-diem rate on record with Division of Medical Services for September 1992 times the projected FY-93 Medicaid days for each qualifying facility allocated based on its February 1992 Medicaid census annualized; and

E. Effective July 1, 1993, and each July 1 after that, any nursing facility licensed under Chapter 198, RSMo and operated by a district or county which receives local tax revenues and certifies these revenues to the Department of Social Services shall receive an adjustment to its per-diem rate. The adjustment shall not exceed ninety percent (90%) of the Medicaid portion of the local tax revenue in aggregate divided by the total projected Medicaid payments for those qualifying facilities. The adjustment will be limited by the class ceiling. Any unused certified local tax revenue will not carry forward into the next state fiscal year's calculation.

(I) The Medicaid portion is determined by multiplying the total local tax revenues certified to the Department of Social Services for each facility by each facility's Medicaid occupancy rate as reported on its most recent desk-reviewed cost report.

(II) The projected Medicaid payments are computed by multiplying the per-diem rate on record with DMS on June 1 each year times the June 1 of each year projected Medicaid days for the following state fiscal year for each qualifying facility allocated based on its reported Medicaid days on the most current cost report on file with DMS.

3. Prospective payment adjustment (PPA). A FY-92 PPA will be provided prior to the end of the state fiscal year for nursing homes with a current provider agreement on file with the DMS as of October 1, 1991, except those facilities that are owned or operated, or both, by the federal government.

A. For nursing homes which qualify, the PPA shall be the lesser of—

(I) The nursing home's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjust-

ment factor (PPAF) times the LTCC on October 1, 1991, (FPGF × PPD × PPAF × LTCC). For example: A nursing home having two thousand seven (2007) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of two million one hundred seventy-five thousand two hundred fifty-seven (2,175,257) represents an FPGF of nine-hundredths percent (.09%). So using the FPGF of .09% × 9,750,000 × 32.5% × \$56.98 = \$167,578; or

(II) The nursing home's FPGF times one hundred forty-five percent (145%) of the amount credited to the nursing facility revenue collection center (NFRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

B. FPGF is determined by using each nursing home's paid days for the service dates in May 1991 through July 1991 as of August 20, 1991, divided by the sum of the paid days for the same service dates for all nursing homes qualifying as of the determination date of September 12, 1991.

C. LTCC is fifty-six dollars and ninety-eight cents (\$56.98) on October 1, 1991.

D. PPAF is equal to thirty-two and five-tenths percent (32.5%) for Fiscal Year 1992 which includes an adjustment for economic trends, Workers' Compensation and heavy care/access incentive.

E. PPD is the projection of nine million seven hundred fifty thousand (9,750,000) patient days made on October 1, 1991, for the adjustment year.

4. Other conditions for per-diem rate adjustments. The division may adjust a facility's per-diem rate both retrospectively and prospectively under the following conditions:

A. Fraud, misrepresentation, errors, audit adjustment. When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of that information. No decision by the Medicaid agency to impose a rate adjustment in the case of fraudulent, misrepresented or inaccurate information in any way shall affect the Medicaid agency's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of this information also does not affect the Medicaid

agency's ability to impose any sanctions authorized by statute or regulation;

B. Decisions of the Administrative Hearing Commission or settlement agreements approved by the Administrative Hearing Commission;

C. Court order; and

D. Disallowance of federal financial participation.

(B) Adjustments Determined by the Division With the Advice of the Rate Advisory Committee.

1. Advisory committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to requests for rate reconsideration which are in accordance with the provisions of paragraph (12)(B)2. The director may accept, reject or modify the advisory committee's recommendations.

A. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department of Social Services and two (2) members who may include, but are not limited to, a consumer representative, an accountant or economist or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

B. Procedures.

(I) The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concurs.

(II) The committee shall meet no less than one (1) time each quarter and members shall be reimbursed for expenses.

(III) The Division of Medical Services will summarize each case and make recommendations. The advisory committee may request additional documentation. Failure to submit requested documentation shall be abandonment of the request.

(IV) The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

(V) The advisory committee shall have ninety (90) days from the receipt of each complete request, or the receipt of any additional documentation, to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee

establishes good cause, may grant a reasonable extension.

(VI) Final determination on rate adjustment. The director or his/her designee's final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

(VII) If the director or his/her designee's final determination allows a rate adjustment, it shall become effective on the first day of the month in which the request was made providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month.

2. Requests for rate adjustments. A participating facility which has a prospective per-diem rate may request adjustment to its prospective per-diem rate only under the conditions described in subparagraph (12)(B)2.A., B. or C. The request must be submitted in writing to the division within one year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify under which of the conditions the rate adjustment is sought. The total dollar amount of the requested rate adjustment must be supported by complete, accurate and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month. Conditions for rate adjustment are—

A. Extraordinary circumstances.

(I) When the provider can show that it incurred higher costs due to circumstances beyond its control; the circumstances were not experienced by the nursing home industry in general; and the costs have a substantial effect.

(II) Extraordinary circumstances include:

(a) Natural disasters; such as fire, earthquakes and flood; 1) that are not

covered by insurance; and 2) that occur in a federally-declared disaster area; and

(b) Vandalism, civil disorder or both.

(III) The per-diem rate increase will be calculated as follows:

(a) To determine what portion of the incurred costs will be paid by the Division of Medical Services, the division will use the quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstance occurred;

(b) For one (1)-time costs (costs which will not be incurred in future fiscal years): The costs directly associated with the extraordinary circumstance will be divided by the paid days for the month the rate adjustment becomes effective per part (12)(B)1.B.(VII). This calculation will equal the amount to be added to the per-diem rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one month only, the LTCC will be waived; and

(c) For on-going or capitalized costs (costs that will be incurred in future fiscal years): Ongoing annual costs (that is, depreciation, interest, etc.) will be divided by the greater of: annualized (calculated for a twelve (12)-month period) total patient days from the latest cost report on file or ninety percent (90%) of annualized total bed days. This calculation will equal the amount to be added to the per-diem rate, not to exceed the LTCC in effect on the date of the increase. This rate adjustment will be added to the per-diem rate;

B. Professional service hours. A rate adjustment may be granted if a facility has experienced an increase in total RN and LPN hours. This increase divided by patient days from the latter period must be at least twenty percent (20%) of the average total RN and LPN hours per patient day for the appropriate period. For adjustments requested in state FY-92, this average will be derived from total RN and LPN hours as identified from cost reports for facilities licensed as SNFs with ending dates after July 1, 1990, and prior to January 1, 1991. For each succeeding state fiscal year, this average will be derived from total RN and LPN hours as identified from cost reports with ending dates in the second calendar year prior to the ending date of the state fiscal year. For example, adjustments requested in state FY-93, the data from cost reports with ending dates in calendar year 1991 will be used. This adjustment is available no more frequently than every two (2) years, with the first adjustment available under this plan to be based upon the twelve

(12)-month facility fiscal year required cost report with a period ending after the effective date of this rule. This cost report will be compared to the required cost report for the succeeding twelve (12)-month facility fiscal year. For example, a facility with a twelve (12)-month cost report ending September 30, 1990, shall compare total RN and LPN hours corresponding to RN and LPN salaries reported on lines forty-nine (49) and fifty (50) of the cost report plus contracted RN and LPN hours corresponding to the contracted costs identified on the cost report, to similar data from the cost report for the twelve (12)-month period ending September 30, 1991. The next available adjustment would be for the twelve (12)-month facility fiscal year required cost report with a period ending September 30, 1993, as compared to the required cost report for the twelve (12)-month period ending September 30, 1991. The adjustment amount will be determined by obtaining the difference in costs per patient day reported for RN and LPN services (salaries, fringe benefits and RN and LPN contract costs) between the two (2) applicable cost reporting periods using the greater of ninety percent (90%) of bed days or actual reported occupancy. The facility must submit copies of the actual payroll records which support the cost report data as well as billings showing RN and LPN contract hours which support the cost report. These records must show job title (RN, LPN), actual hours worked, the per-hour rate and the total amount paid for each employee. Any salaried RN or LPN employee will be assumed to be working a forty (40)-hour week for all weeks worked; and

C. Additional beds. The division may recommend a rate adjustment for a participating facility which has a prospective per-diem rate in effect, and which increases its bed capacity after July 1, 1990, in accordance with an approved CON or applicable waiver. The recommended rate adjustment will be calculated as the difference between the weighted average allowable capital costs per day as defined in part (12)(B)2.C.(I) and the allowable capital cost per day as determined in subsection (7)(Q).

(I) The weighted average allowable capital cost per day is calculated as the sum of subparts (12)(B)2.C.(I)(a) and (b) divided by the total number of certified beds.

(a) The allowable capital cost per day as determined in subsection (7)(Q) multiplied by the number of existing certified beds.

(b) The allowable capital cost per day for new beds as described in paragraph (7)(Q)2. multiplied by the number of new certified beds, except the movable equipment

rate described in subparagraph (7)(Q)2.B. shall be sixty-five cents (65¢) per bed day which equates to two hundred twenty dollars (\$220) per bed.

(13) Exceptions.

(A) For those Medicaid-eligible recipient patients who have concurrent Medicare Part A SNF benefits available, Missouri Medical Assistance Program reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of fewer than one thousand (1000) patient days for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers which provided services of one thousand (1000) or more patient days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate as calculated in section (11).

(14) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this rule, the division also may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(15) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may seek a hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

(16) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these rules and applicable copayments.

(17) Provider Participation. Payments made in accordance with the standards and methods

described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the state plan at least to the extent these services are available to the general public.

(18) Transition. Cost reports used for rate determination shall be adjusted by the division in accordance with the applicable cost principles provided in this rule.

**APPENDIX A  
Covered Supplies & Services**

**Personal Care—**

- Baby Powder
- Bedsheet Tissues
- Bids (all types)
- Deodorants
- Disposable Underpads (all types)
- Gowns, Hospital
- Hair Care, Basic (including washing, cuts, sets, brushes, combs, nonlegend shampoo)
- Lotion, Soap and Oil
- Nail Clipping and Cleaning Routine
- Oral Hygiene (including denture care, cups, cleaner, mouthwashes, toothbrushes and paste)
- Shaves, Shaving Cream and Blades

**Equipment—**

- Arm Slings
- Basins
- Bathing Equipment
- Bed Frame Equipment (including trapeze bars and bedrails)
- Bed Pans (all types)
- Beds, Manual, Electric
- Canes (all types)
- Crutches (all types)
- Foot Cradles (all types)
- Glucometers
- Heat Cradles
- Heating Pads
- Hot Pack Machines
- Hypothermia Blanket
- Mattresses (all types)
- Patient Lifts (all types)
- Respiratory Equipment (compressors, vaporizers, Humidifiers, Intermittent Positive Pressure Breathing Machines (IPPB), nebulizers, suction equipment and related supplies and the like)
- Restraints
- Sand Bags
- Specimen Container (cup or bottle)
- Urinals (male and female)
- Walkers (all types)
- Water Pitchers
- Wheelchairs (standard, geriatric and rollout)

**Nursing Care/Patient Care Supplies—**

- Catheter (indwelling and nonlegend supplies)
- Decubitus Ulcer Care (pads, dressings, air mattresses, aquamatic K-pads (water-heated pads), alternating pressure pads, flotation pads, or turning frames, or any combination of these, heel protectors, donuts and sheepskins)
- Diabetic Blood and Urine Testing Supplies
- Douche Bags
- Drainage Sets, Bags, Tubes and the like
- Dressing Trays (dressings of all types)
- Enema Supplies
- Gloves (nonsterile and sterile)
- Ice Bags
- Incontinency Care (including pads, diapers and pants)
- Irrigation Trays and Nonlegend Supplies
- Medicine Cups
- Medicine Droppers
- Needles (including, but not limited to, hypodermic, scalp, vein)
- Nursing Services (regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel)
- Nursing Supplies: Lubricating Jelly, Beta-dine, Benzoin, Peroxide, A & D Ointment, Tapes, Alcohol, Alcohol Sponges, Applicators, Dressings and Bandages (of all types), Cottonballs, Merthiolate Aerosol and Tongue Depressors
- Ostomy Supplies (adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures and bags)
- Suture Care (including trays and removal kits)
- Syringes, all sizes and types (including Ascepto)
- Tape (for laboratory tests)
- Urinary Drainage Tube and Bottle

**Therapeutic Agents and Supplies—  
Antacids, Nonlegend**

- Drugs, Stock (excluding Insulin)
- Enteral Feedings (including by tube, and all related supplies)
- I.V. Therapy Supplies (arm boards, needles, tubing and other related supplies)
- Laxatives, Nonlegend
- Oxygen (portable or stationary), Oxygen Delivery Systems, Concentrators and Supplies
- Special Diets
- Stool Softeners, Nonlegend
- Vitamins, Nonlegend

**Other Services and Supplies as Otherwise Determined**

*AUTHORITY: sections 208.153, 208.159 and 208.201, RSMo 1994.\* This rule was previously filed as 13 CSR 40-81.081. Emergency rule filed Sept. 18, 1981, effective Oct. 1, 1981, expired Jan. 13, 1982. Original rule filed Sept. 18, 1981, effective Jan. 14, 1982. Emergency amendment filed Sept. 28, 1981, effective Oct. 7, 1981, expired Jan. 13, 1982. Amended: Filed Oct. 13, 1981, effective Jan. 14, 1982. Emergency amendment filed June 21, 1982, effective July 1, 1982, expired Oct. 10, 1982. Amended: Filed June 21, 1982, effective Oct. 11, 1982. Emergency amendment filed Oct. 8, 1982, effective Oct. 18, 1982, expired Jan. 12, 1983. Amended: Filed Oct. 8, 1982, effective Jan. 13, 1983. Amended: Filed March 14, 1985, effective July 11, 1985. Emergency amendment filed June 20, 1985, effective July 1, 1985, expired Sept. 30, 1985. Amended: Filed June 20, 1985, effective Oct. 1, 1985. Amended: Filed Aug. 2, 1985, effective Nov. 1, 1985. Amended: Filed Dec. 16, 1985, effective April 25, 1986. Amended: Filed April 16, 1986, effective July 1, 1986. Amended: Filed June 17, 1986, effective Sept. 1, 1986. Emergency amendment filed June 30, 1986, effective July 10, 1986, expired Nov. 7, 1986. Amended: Filed July 3, 1986, effective Oct. 11, 1986. Amended: Filed July 3, 1986, effective Nov. 1, 1986. Amended: Filed Aug. 1, 1986, effective Nov. 13, 1986. Amended: Filed Dec. 16, 1986, effective April 26, 1987. Emergency amendment filed June 19, 1987, effective July 1, 1987, expired Oct. 29, 1987. Emergency amendment filed Aug. 18, 1987, effective Aug. 28, 1987, expired Dec. 25, 1987. Amended: Filed Aug. 18, 1987, effective Dec. 12, 1987. Amended: Filed Aug. 18, 1987, effective Oct. 25, 1987. Emergency amendment filed July 28, 1988, effective Aug. 6, 1988, expired Dec. 3, 1988. Emergency amendment filed Oct. 4, 1988, effective Oct. 14, 1988, expired Dec. 4, 1988. Amended: Filed Dec. 5, 1988, effective Feb. 24, 1989. Emergency amendment filed Dec. 16, 1988, effective Jan. 1, 1989, expired May 1, 1989. Amended: Filed Dec. 16, 1988, effective March 11, 1989. Amended: Filed March 3, 1989, effective May 15, 1989. Amended: Filed Aug. 16, 1989, effective Nov. 11, 1989. Amended: Filed March 5, 1990, effective June 11, 1990. Emergency rescission and rule filed June 1, 1990, effective July 1, 1990, expired Oct. 28, 1990. Rescinded and readopted: Filed June 1, 1990, effective Sept. 28, 1990. Emergency amendment filed March 4, 1991, effective April 1, 1991, expired July 29, 1991. Amended: Filed March 4, 1991, effective July 8, 1991. Amended: Filed March 18, 1991, effective July 8, 1991. Amended: Filed May 2, 1991, effective Sept. 30, 1991.*

*Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Amended: Filed June 26, 1991, effective Dec. 9, 1991. Amended: Filed Sept. 4, 1991, effective Jan. 13, 1992. Emergency amendment filed Oct. 9, 1991, effective Oct. 29, 1991, expired Feb. 25, 1992. Emergency amendment filed Nov. 15, 1991, effective Dec. 3, 1991, expired April 1, 1992. Amended: Filed Nov. 15, 1991, effective April 9, 1992. Emergency amendment filed March 13, 1992, effective April 2, 1992, expired July 30, 1992. Amended: Filed Feb. 3, 1992, effective June 25, 1992. Amended: Filed March 30, 1992, effective Sept. 6, 1992. Amended: Filed May 5, 1992, effective Jan. 15, 1993. Amended: Filed May 15, 1992, effective Jan. 15, 1993. Emergency amendment filed June 16, 1992, effective July 1, 1992, expired Oct. 28, 1992. Emergency amendment filed June 16, 1992, effective July 1, 1992, expired Oct. 28, 1992. Emergency amendment filed June 26, 1992, effective July 5, 1992, expired Oct. 28, 1992. Emergency amendment filed July 23, 1992, effective Aug. 2, 1992, expired Nov. 29, 1992. Emergency amendment filed July 23, 1992, effective Aug. 2, 1992, expired Nov. 29, 1992. Emergency amendment filed Sept. 25, 1992, effective Oct. 29, 1992, expired Feb. 25, 1993. Emergency amendment filed Sept. 25, 1992, effective Nov. 1, 1992, expired Feb. 27, 1993. Emergency amendment filed Nov. 16, 1992, effective Nov. 30, 1992, expired March 29, 1993. Emergency amendment filed Nov. 16, 1992, effective Nov. 30, 1992, expired March 29, 1993. Amended: Filed June 16, 1992, effective Feb. 26, 1993. Amended: Filed Sept. 25, 1992, effective May 6, 1993. Amended: Filed Oct. 15, 1992, effective May 6, 1993. Emergency amendment filed Feb. 18, 1993, effective March 1, 1993, expired June 28, 1993. Amended: Filed Feb. 5, 1993, effective July 8, 1993. Emergency amendment filed Feb. 16, 1993, effective Feb. 26, 1993, expired June 25, 1993. Emergency amendment filed Feb. 16, 1993, effective Feb. 28, 1993, expired June 27, 1993. Amended: Filed Feb. 18, 1993, effective Sept. 9, 1993. Emergency amendment filed June 15, 1993, effective July 1, 1993, expired Oct. 28, 1993. Emergency amendment filed May 20, 1993, effective June 1, 1993, expired Sept. 28, 1993. Emergency amendment filed June 15, 1993, effective June 30, 1993, expired Oct. 27, 1993. Emergency amendment filed Aug. 17, 1993, effective Sept. 1, 1993, expired Dec. 29, 1993. Amended: Filed June 3, 1993, effective Dec. 9, 1993. Amended: Filed June 15, 1993, effective Dec. 9, 1993. Emergency amendment filed Aug. 17, 1993, effective Sept. 1, 1993, expired Dec. 29,*

*1993. Emergency amendment filed Oct. 15, 1993, effective Oct. 29, 1993, expired Feb. 25, 1994. Amended: Filed Aug. 17, 1993, effective March 10, 1994. Amended: Filed Nov. 2, 1993, effective June 6, 1994. Emergency amendment filed Dec. 17, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency amendment filed Dec. 17, 1993, effective Jan. 1, 1994, expired April 28, 1994. Amended: Filed Dec. 2, 1993, effective July 30, 1994. Emergency amendment filed April 19, 1994, effective May 1, 1994, expired Aug. 28, 1994. Amended: Filed Feb. 16, 1994, effective Aug. 28, 1994. Emergency amendment filed June 15, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Sept. 20, 1994, effective Oct. 1, 1994, expired Jan. 28, 1995. Emergency amendment filed Oct. 7, 1994, effective Oct. 29, 1994, expired Feb. 25, 1995. Amended: Filed June 15, 1994, effective Jan. 29, 1995. Emergency amendment filed Sept. 20, 1994, effective Oct. 1, 1994, expired Jan. 28, 1995. Emergency amendment filed Oct. 7, 1994, effective Oct. 29, 1994, expired Feb. 25, 1995. Amended: Filed Sept. 20, 1994, effective May 28, 1995.*

*\*Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; 208.159, RSMo 1979; and 208.201, RSMo 1987.*



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0067

QUARTERLY MEDICAID STATEMENT OF EXPENDITURES  
FOR THE MEDICAL ASSISTANCE PROGRAM

STATE	
AGENCY	
QUARTER ENDED	19

CERTIFICATION

FORM HCFA-64 SUMMARY SHEET SUBMITTED	MEDICAL ASSISTANCE PAYMENTS		STATE AND LOCAL ADMINISTRATION	
	TOTAL COMPUTABLE (a)	FEDERAL SHARE (b)	TOTAL COMPUTABLE (c)	FEDERAL SHARE (d)
NET EXPENDITURES REPORTED ON LINE 11.				

I, EXECUTIVE OFFICER OF THE STATE AGENCY CHARGED WITH THE DUTIES OF ADMINISTERING (OR SUPERVISING THE ADMINISTRATION OF) THE STATE PLAN FOR THE MEDICAID PROGRAM AS PROVIDED FOR IN THE SOCIAL SECURITY ACT, AS AMENDED, DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM HCFA-64 SUMMARY SHEET AND THE SUPPORTING FORMS AND SCHEDULES IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE	SIGNATURE	TITLE

FORWARD THE COMPLETED QUARTERLY STATEMENT OF EXPENDITURES (SUMMARY SHEET) WITH SUPPORTING COMPUTATION FORM(S) AND SCHEDULE(S) TO THE HEALTH CARE FINANCING ADMINISTRATION, BUREAU OF QUALITY CONTROL, OMM, DFM, BUDGET AND GRANTS BRANCH, P. O. BOX 26678, ROOM 281 EAST HIGH RISE, BALTIMORE, MARYLAND 21207-0278.

IF YOU TRANSMITTED YOUR FORMS USING THE AUTOMATED MEDICAID BUDGET AND EXPENDITURE SYSTEM, FORWARD ONLY A COMPLETED CERTIFICATION SHEET.



FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		QUARTERLY MEDICAID STATEMENT OF EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM SUMMARY SHEET			STATE
		MEDICAL ASSISTANCE PAYMENTS	TOTAL COMPUTABLE	TOTAL COMPUTABLE	FEDERAL SHARE
		(b)	(c)	(c)	(d)
SECTION A					
QUARTERLY STATUS OF FUNDING					
1.	AWARDS RECEIVED DURING THE QUARTER FOR THE QUARTER BEING REPORTED AND PRIOR QUARTERS				
2.	AWARDS RECEIVED DURING THE QUARTER FOR SUBSEQUENT QUARTER				
3.	INTEREST:				
	A. RECEIVED ON MEDICAID RECOVERIES				
	B. ASSESSED ON DISALLOWANCES				
4.	MEDICARE OVERPAYMENT COLLECTIONS UNDER SEC. 1914 AND 42 C.F.R. 447.30				
5.					
SECTION B					
EXPENDITURES REPORTED FOR PERIOD					
6.	EXPENDITURES IN THIS QUARTER (ATTACH 64.9 AND/OR 64.10)				
7.	ADJUSTMENTS INCREASING CLAIMS FOR PRIOR QUARTERS (ATTACH 64.9p AND/OR 64.10p)				
8.	OTHER EXPENDITURES (ATTACH 64.9p AND/OR 64.10p)				
9.	COLLECTIONS:				
	A. THIRD PARTY LIABILITY COLL. (ATTACH 64.9a)				
	B. PRORATE COLLECTIONS				
	C. COLLECTIONS IDENTIFIED THROUGH FRAUD AND ABUSE EFFORT				
	D. OTHER COLLECTIONS				
	E.				
10.	ADJUSTMENTS DECREASING CLAIMS FOR PRIOR QUARTERS:				
	A. FEDERAL AUDIT (ATTACH 64.9p AND/OR 64.10p)				
	B. OTHER (ATTACH 64.9p AND/OR 64.10p)				
	C. OVERPAYMENT ADJUSTMENTS (ATTACH 64.9c)				
11.	NET EXPENDITURES REPORTED IN THIS PERIOD (SUM OF ITEMS 6., 7., AND 8. LESS 9. AND 10.)				



FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE  
MEDICAL ASSISTANCE PROGRAM  
EXPENDITURES IN THIS QUARTER

	STATE		FEDERAL SHARE		TOTAL FEDERAL SHARE
	AGENCY	QUARTER ENDED	I.H.S. FACILITY SERVICES 100%	FAMILY PLANNING SERVICES 90%	
			(b) %	(c) %	
TOTAL COMPUTABLE	(a)		(c)	(d)	(f)
MEDICAL ASSISTANCE PAYMENTS TYPE OF WAIVER _____ WAIVER NUMBER _____					
1. A. INPATIENT HOSPITAL SERVICES					
B. MENTAL HEALTH FACILITY SERVICES					
C. SKILLED NURSING FACILITY SERVICES					
D. INTERMEDIATE CARE FACILITY SERVICES: (1) MENTALLY RETARDED a. PUBLIC PROVIDERS b. PRIVATE PROVIDERS					
(2) ALL OTHER					
E. PHYSICIANS' SERVICES					
F. OUTPATIENT HOSPITAL SERVICES					
G. PRESCRIBED DRUGS					
H. DENTAL SERVICES					
I. OTHER PRACTITIONERS' SERVICES					
J. CLINIC SERVICES					
K. LABORATORY AND RADIOLOGICAL SERVICES					



FORM APPROVED  
OMB NO. 0938-0087

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE MEDICAL ASSISTANCE PROGRAM EXPENDITURES IN THIS QUARTER		STATE		TOTAL FEDERAL SHARE
		AGENCY	QUARTER ENDED	
TOTAL COMPUTABLE	FMAP %	I.H.S. FACILITY SERVICES 100%	FAMILY PLANNING SERVICES 90%	TOTAL FEDERAL SHARE
(a)	(b)	(c)	(d)	(f)
MEDICAL ASSISTANCE PAYMENTS				
TYPE OF WAIVER				
WAIVER NUMBER				
L HOME HEALTH SERVICES				
M STERILIZATIONS				
N ABORTIONS				
O EPSDT SCREENING SERVICES				
P RURAL HEALTH CLINIC SERVICES				
Q HEALTH INSURANCE PAYMENTS				
(1) PART B PREMIUMS				
(2) COINSURANCE AND DEDUCTIBLES				
(3) OTHER				
R HOME AND COMMUNITY-BASED SERVICES <sup>1</sup>				
S PERSONAL CARE SERVICES				
T TARGETED CASE MANAGEMENT SERVICES				
U HOSPICE BENEFITS				
V OTHER CARE SERVICES				
W				
2. TOTAL (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET, LINE 6, COLUMNS (a) AND (b)).				

<sup>1</sup> IF STATE HAS MORE THAN ONE APPROVED HCBS WAIVER, ATTACH SCHEDULE SHOWING EXPENDITURES FOR EACH APPROVED WAIVER.

FORM HCFA 64-S, LINE 6 (4-88)

PAGE 2 OF 2



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0067

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE MEDICAL ASSISTANCE PROGRAM PRIOR PERIOD ADJUSTMENTS**

CHECK ONE  LINE 7.  LINE 8.  LINE 10.A.  LINE 10.B.

STATE \_\_\_\_\_ FISCAL YEAR \_\_\_\_\_  
 AGENCY \_\_\_\_\_  
 QUARTER ENDED \_\_\_\_\_, 19\_\_

MEDICAL ASSISTANCE PAYMENTS TYPE OF WAIVER WAIVER NUMBER	TOTAL COMPUTABLE (a)	FEDERAL SHARE			TOTAL FEDERAL SHARE (f)	DEFERRAL, DISALLOWANCE OR C.I.N. NO. (g)
		FMAP % (b)	I.H.S. FACILITY SERVICES 100% (c)	FAMILY PLANNING SERVICES 90% (d)		
1. A. INPATIENT HOSPITAL SERVICES						
B. MENTAL HEALTH FACILITY SERVICES						
C. SKILLED NURSING FACILITY SERVICES						
D. INTERMEDIATE CARE FACILITY SERVICES (1) MENTALLY RETARDED a. PUBLIC PROVIDERS b. PRIVATE PROVIDERS						
(2) ALL OTHER						
E. PHYSICIANS' SERVICES						
F. OUTPATIENT HOSPITAL SERVICES						
G. PRESCRIBED DRUGS						
H. DENTAL SERVICES						
I. OTHER PRACTITIONERS' SERVICES						
J. CLINIC SERVICES						
K. LABORATORY AND RADIOLOGICAL SERVICES						



FORM APPROVED  
OMB NO. 0936-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE  
MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS

STATE \_\_\_\_\_ FISCAL YEAR \_\_\_\_\_  
AGENCY \_\_\_\_\_  
QUARTER ENDED \_\_\_\_\_ 19\_\_

CHECK ONE	LINE 7.		LINE 8.		LINE 10.A.		LINE 10.B.	
	TYPE OF WAIVER	WAIVER NUMBER	TOTAL COMPUTABLE	FMAP %	I.H.S. FACILITY SERVICES 100%	FAMILY PLANNING SERVICES 90%	TOTAL FEDERAL SHARE %	DEFERRAL, DISALLOWANCE OR C.I.N. NO.
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	
L. HOME HEALTH SERVICES								
M. STERILIZATIONS								
N. ABORTIONS								
O. EPSDT SCREENING SERVICES								
P. RURAL HEALTH CLINIC SERVICES								
Q. HEALTH INSURANCE PAYMENTS								
(1) PART B PREMIUMS								
(2) COINSURANCE AND DEDUCTIBLES								
(3) OTHER								
R. HOME AND COMMUNITY-BASED SERVICES								
S. PERSONAL CARE SERVICES								
T. TARGETED CASE MANAGEMENT SERVICES								
U. HOSPICE BENEFITS								
V. OTHER CARE SERVICES								
W.								
2 TOTAL (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET LINE 7, 8, 10.A. OR 10.B. COLUMNS (a) AND (b) AS APPROPRIATE).								

IF STATE HAS MORE THAN ONE APPROVED HCBS WAIVER, ATTACH SCHEDULE SHOWING EXPENDITURES FOR EACH APPROVED WAIVER.



FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

THIRD PARTY LIABILITY COLLECTIONS AND COST AVOIDANCE	STATE	FEDERAL SHARE
	AGENCY	(b)
	QUARTER ENDED	
A. THIRD PARTY LIABILITY COLLECTIONS	TOTAL COMPUTABLE (a)	
1. AMOUNT OF THIRD PARTY LIABILITY COLLECTIONS MADE IN THIS QUARTER BY SOURCE:		.19
(a) MEDICARE TITLE XVIII		
(b) OTHER COLLECTIONS; DO NOT ENTER THOSE MADE UNDER SECTIONS 1903(p) AND 1912		
(1) HEALTH INSURANCE		
(2) CASUALTY INSURANCE		
(c) TOTAL COLLECTIONS UNDER COOPERATIVE AGREEMENTS SECTION 1903(p) AND ASSIGNMENT OF RIGHTS SECTION 1912		
(1) LESS: EXCESS PAID TO INDIVIDUALS		
(2) NET COLLECTIONS TO REIMBURSE STATE TITLE XIX MEDICAL PAYMENTS (ITEM 1.(c)(1))		
(3) LESS 15% INCENTIVE ACTUALLY PAID UNDER SECTION 1903(p)(1)		
(4) NET FEDERAL SHARE OF COLLECTIONS REPORTABLE (ITEM 1.(c)(2) LESS 1.(c)(3))		
2. TOTAL THIRD PARTY LIABILITY COLLECTIONS (ENTER COLUMNS (a) AND (b) ON SUMMARY SHEET LINE 9 A. COLUMNS (a) AND (b). COLUMN (a) TOTAL COMPUTABLE AMOUNT IS THE SUM OF ITEMS 1.(a), 1.(b)(1), 1.(b)(2) AND 1.(c)(2). COLUMN (b) FEDERAL SHARE IS THE SUM OF ITEMS 1.(a), 1.(b)(1), 1.(b)(2) AND 1.(c)(4).		
B. COST AVOIDANCE		
1. MEDICARE TITLE XVIII		
2. HEALTH INSURANCE		
3. OTHER COST AVOIDANCE		

FORM HCFA-64 9a (4-88)



FORM APPROVED  
OMB NO. 0938-0087

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

**MEDICAID OVERPAYMENT ADJUSTMENTS**

	STATE _____					
	AGENCY _____					
	QUARTER ENDED _____, 19__					
	TOTAL COMPUTABLE (a)	FY (b)	FY (c)	FY (d)	FY (e)	TOTAL FEDERAL SHARE (f)
OVERPAYMENT ACTIVITY						
1. OVERPAYMENTS NOT COLLECTED OR ADJUSTED BUT REFUNDED BECAUSE OF THE EXPIRATION OF THE 60-DAY TIME LIMIT						
2. DECREASING ADJUSTMENTS TO AMOUNTS PREVIOUSLY REPORTED ON LINE 1.						
3. SUBTOTAL (LINE 1, MINUS LINE 2.)						
4. PREVIOUSLY REPORTED OVERPAYMENTS TO PROVIDERS CERTIFIED THIS QUARTER AS BANKRUPT OR OUT OF BUSINESS						
5. TOTAL OVERPAYMENT ADJUSTMENTS THIS QUARTER (LINE 3, MINUS LINE 4). (ENTER COLUMNS (b) AND (f) ON SUMMARY SHEET LINE 10.C., COLUMNS (a) AND (g), RESPECTIVELY.)						

FORM HCFA-64.9b (4-88)



FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION  
FOR THE MEDICAL ASSISTANCE PROGRAM  
EXPENDITURES IN THIS QUARTER

TYPE OF WAIVER WAIVER NUMBER	TOTAL COMPUTABLE (a)	STATE AGENCY QUARTER ENDED			TOTAL FEDERAL SHARE (f)
		90% (b)	75% (c)	50% (d)	
1. FAMILY PLANNING					
2. DESIGN, DEVELOPMENT OR INSTALLATION OF MMIS: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS					
B. COST OF PRIVATE SECTOR CONTRACTORS					
J. SKILLED PROFESSIONAL MEDICAL PERSONNEL					
4. OPERATION OF AN APPROVED MMIS: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS					
B. COST OF PRIVATE SECTOR CONTRACTORS					
5. MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS					
B. COST OF PRIVATE SECTOR CONTRACTORS					
6. PEER REVIEW ORGANIZATIONS (PRO)					
7. OTHER FINANCIAL PARTICIPATION					
K. A. THIRD PARTY LIABILITY RECOVERY PROCEDURE—BILLING OFFSET					
B. ASSIGNMENT OF RIGHTS—BILLING OFFSET					
IMMIGRATION STATUS VERIFICATION SYSTEM COSTS (100% FFP)					
10. NURSE AIDE TRAINING COSTS					
11. PREAMMISSION SCREENING COSTS					
12. RESIDENT REVIEW ACTIVITIES COSTS					
13.					
14. TOTAL (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET LINE 6 COLUMNS (c) AND (d)).					

FORM HCFA-64.10. LINE 6 (4-88)



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0067

**EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION  
FOR MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS**

STATE \_\_\_\_\_ FISCAL YEAR \_\_\_\_\_

AGENCY \_\_\_\_\_

QUARTER ENDED \_\_\_\_\_, 19\_\_

CHECK ONE <input type="checkbox"/> LINE 7. TYPE OF WAIVER WAIVER NUMBER _____	LINE 10.A.			TOTAL COMPUTABLE (a)	FEDERAL SHARE			TOTAL FEDERAL SHARE (f)	DEFERRAL, DISALLOWANCE OR C.I.N. NO. (g)
	<input type="checkbox"/> LINE 8.	90% (b)	75% (c)		50% (d)	% (e)			
1. FAMILY PLANNING									
2. DESIGN, DEVELOPMENT OR INSTALLATION OF MMIS: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS									
B. COST OF PRIVATE SECTOR CONTRACTORS									
3. SKILLED PROFESSIONAL MEDICAL PERSONNEL									
4. OPERATION OF AN APPROVED MMIS: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS									
B. COST OF PRIVATE SECTOR CONTRACTORS									
5. MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS									
B. COST OF PRIVATE SECTOR CONTRACTORS									
6. PEER REVIEW ORGANIZATIONS (PRO)									
7. OTHER FINANCIAL PARTICIPATION									
8. A. TPL RECOVERY PROCEDURE—BILLING OFFSET									
1. ASSIGNMENT OF RIGHTS—BILLING OFFSET									
3. IMMIGRATION STATUS VERIFICATION SYSTEM COSTS (100% FFP)									
10. NURSE AIDE TRAINING COSTS									
11. PREADMISSION SCREENING COSTS									
12. RESIDENT REVIEW ACTIVITIES COSTS									
13.									
14. TOTAL (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET LINE 7, 8, 10.A., OR 10.B., COLUMNS (c) AND (d).)									

### 13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services

*PURPOSE: This rule establishes a payment plan for long-term care required by the Code of Federal Regulations. The plan describes principles to be followed by Title XIX long-term care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing the cost reports.*

*PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.*

(1) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (department), Division of Medical Services (division), to promulgate rules and regulations.

(2) Purpose. This regulation establishes a methodology for determination of reimbursement rates for nursing facilities. Subject to limitations prescribed elsewhere in this regulation, a facility's reimbursement rate shall be determined by the division as described in this regulation. Any reimbursement rate determined, by the division, that has been appealed in a timely manner shall not be final until there is a final decision. Federal financial participation is available on expenditures for services provided within the scope of the federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement regulation shall apply only to facilities certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement rates determined by this regulation shall apply only to services provided on or after January 1, 1995.

(C) The effective date of this regulation shall be January 1, 1995.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid-eligible recipient's covered days of care, within benefit limitations as determined in subsections (5)(D) and (M) multiplied by the facili-

ty's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this plan. Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as vocational rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of—

1. The Medicare (Title XVIII) rate, if applicable; or

2. The reimbursement rate as determined in accordance with sections (11)–(13).

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When a nursing facility is found not in compliance with federal requirements for participation in the Medicaid Program, sections 1919(b), (c) and (d) of the Social Security Act (42 U.S.C. 1396r), it may be terminated from the Medicaid Program or it may have imposed upon it an alternative remedy, pursuant to section 1919(h) of the Social Security Act (42 U.S.C. 1396r). In accordance with section 1919(h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken in accordance with the approved plan and timetable. It is also required that the nursing facility establish a directed plan of correction in conjunction with and acceptable to the Division of Aging.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the division. Facilities previously certified shall retain the same provider number regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the division shall recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid Program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement and etc.

(K) A facility with certified and noncertified beds shall allocate allowable costs related to the provision of nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the Medicaid Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by federal or state regulation, be placed on a recipient's right to select providers of his/her own choice.

(N) The average Medicaid reimbursement rate paid shall not exceed the average private pay rate for the same period covered by the facility's Medicaid cost report. Any amount in excess will be subject to repayment and/or recoupment. The comparison of the average Medicaid reimbursement rate paid to the average private pay rate paid will not result in a repayment and/or recoupment until a facility has filed a cost report with a fiscal year ending after January 1, 2002. For example, a nursing facility with a December 31, 2001, year-end cost report would not be used in the private pay rate comparison while a cost report ending on January 31, 2002, would be used in this comparison. This comparison will not be performed for any nursing facility licensed under Chapter 198, RSMo and operated by a district, city or county and receives local tax revenues.

(O) The reimbursement rates authorized by this regulation may be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as food, laundry supplies, housekeeping supplies, linens, medical supplies, but not limited to, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least



annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid-eligible resident while placed in a noncertified bed in a nursing facility.

(R) All illustrations and examples provided throughout this regulation are for illustration purposes only and are not meant to be actual calculations.

(S) Each state fiscal year the department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by nursing facilities during the course of one (1) year. The submission of the budget item by the department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components. For facilities with allowable costs from their 1992 desk audited and/or field audited cost report as determined in sections (11)–(13) of this regulation that are below the facilities' January 1, 1994 reimbursement rate, any granted trend factor shall be limited to the product of the new plan rate divided by the January 1, 1994, (old plan rate) times the facility's trend factor. For example:

New Plan Rate (1-1-95)	\$49.19
January 1, 1994 Rate	\$54.32
Proposed Trend Factor	\$ 1.88
Adjusted Trend Factor	\$ 1.70
	$(\$49.19/\$54.32) * \$1.88$
	$90.55\% * \$1.88 = \$1.70$

The rate after the trend factor would be \$56.02 (\$54.32 + \$1.70).

(T) Rebasing.

1. The division based on its discretion shall pick at least one (1) cost report year from cost reports with fiscal years ending in 1995 through 1999 to compare the allowable costs from the selected desk audited and/or field audited cost report year to the reimbursement rate in effect at the time of the comparison. Each facility's reimbursement rate will be increased or decreased to reflect the allowable costs from the desk audited and/or field audited cost report selected above.

2. The asset value will be adjusted annually based on the R. S. Means Construction Index. The asset value as adjusted will be used only for determining reimbursement in section (11) for the year(s) selected above for rebasing and as determined in paragraphs (13)(B)6. and (13)(B)7.

(4) Definitions.

(A) Additional beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Division of Aging or Department of Health.

(B) Administration. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 105, 113–120, 122–140, 142–144, 147–150, 152–158 and amortization of organizational costs reported on line 106.

(C) Age of beds. The age is determined by subtracting the initial licensing year from 1994 or the current year, if later.

(D) Allowable cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this regulation. The allowability of costs shall be determined by the Division of Medical Services and shall be based upon criteria and principles included in this regulation, the *Medicare Provider Reimbursement Manual* (HIM-15) and GAAP. Criteria and principles will be applied using this regulation as the first source, the *Medicare Provider Reimbursement Manual* (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 62–75, 87–95, 97–103, 145–146.

(F) Asset value. The asset value is thirty-two thousand three hundred thirty dollars (\$32,330) and is used in calculating the Fair Rental Value System.

(G) Average private pay rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with state or federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health. Bad debts, charity care and other miscellaneous discounts are excluded in the computation of the average private pay rate.

(H) Bad debt. The difference between the amount expected to be received and the amount actually received. This amount may be written off as uncollectible after all collection efforts are exhausted. Collection efforts must be documented and an aged

accounts receivable schedule should be kept. Written procedures should be maintained detailing how, when and by whom a receivable may be written off as a bad debt.

(I) Capital. This cost component will be calculated using a fair rental value system. The fair rental value is reimbursed in lieu of the costs reported on lines 106–112 of the cost report version MSIR-1 (7-93) except for amortization of organizational costs.

(J) Capital asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(K) Capital asset debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(L) Ceiling. The ceiling is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is one hundred twenty percent (120%) for patient care, one hundred twenty percent (120%) for ancillary and one hundred ten percent (110%) for administration.

(M) Certified bed. Any nursing facility or hospital based bed that is certified by the Division of Aging or Department of Health to participate in the Medicaid Program.

(N) Change of ownership. A change in ownership, control, operator or leasehold interest, for any facility certified for participation in the Medicaid Program.

(O) Charity care. Offset to gross billed charges to reduce charges for free services provided to specific types of residents, i.e. charity care provided to meet Hill Burton Fund obligations or care provided by a religious organization for members, etc.

(P) Contractual allowance. A contra revenue account to reduce gross charges to the amount expected to be received. Contractual allowances represent the difference between the private pay rate and a contracted rate which the facility contracted with an outside party for full payment of services rendered (i.e. Medicaid, Medicare, managed care organizations, etc.). No efforts are made to collect the difference.

(Q) Cost components. The groupings of allowable costs used to calculate a facility's per-diem rate. They are patient care, ancillary, capital and administration. In addition, a working capital allowance is provided.

(R) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)8. of this regulation and all worksheets supplied by the division for this purpose. The cost report shall detail the cost

of rendering both covered and noncovered services for the fiscal reporting period in accordance with this regulation, cost report instruction and on forms or diskettes provided by and/or as approved by the division.

(S) Data bank. The data from the desk audited and/or field audited 1992 cost report excluding hospital based, state operated and pediatric nursing facilities. This data is adjusted for the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total adjustment of 10.6%. If a facility has more than one (1) cost report with periods ending in calendar year 1992, the cost report covering a full twelve (12)-month period ending in calendar year 1992 will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in calendar year 1992 will be used. Any changes to the desk audited and/or field audited 1992 cost reports made after the effective date of this regulation will not be included in the data bank.

(T) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(U) Desk audit. The Division of Medical Services' or its authorized agent's audit of a provider's cost report without a field audit.

(V) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(W) Division of Aging. The division of the Department of Social Services responsible for survey, certification and licensure as prescribed in Chapter 198, RSMo.

(X) Division. Unless otherwise specified, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) Program.

(Y) Entity. Any natural person, corporation, business, partnership or any other fiduciary unit.

(Z) Facility asset value. Total asset value less adjustment for age of beds.

(AA) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(BB) Facility size. The number of licensed nursing facility beds as determined from the desk audited and/or field audited cost report.

(CC) Fair rental value system. The methodology used to calculate the reimbursement of capital.

(DD) Field audit. An on-site audit of the nursing facility's records performed by the department or its authorized agent.

(EE) Generally accepted accounting principles (GAAP). Accounting conventions, practices, methods, rules and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(FF) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this regulation is titled "DRI Health Care Cost—National Forecasts, HFCA Nursing Home Without Capital Market Basket."

(GG) Hospital based. Any nursing facility bed licensed and certified by the Department of Health.

(HH) Interim rate. The interim rate is the sum of one hundred percent (100%) of the patient care cost component ceiling, ninety percent (90%) of the ancillary and administration cost component ceilings, ninety-five percent (95%) of the median per diem for the capital cost component, and the working capital allowance using the interim rate cost component. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on January 1, 1995.

(II) Licensed bed. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the Division of Aging or the Missouri Department of Health.

(JJ) Miscellaneous discounts/other revenue deductions. A contra revenue account to reduce gross charges to the amount expected to be received. These deductions represent other miscellaneous discounts not specifically defined as a bad debt. Written policies must be maintained detailing the circumstances under which the discounts are available and must be uniformly applied.

(KK) Median. The middle value in a distribution, above and below which lie an equal number of values. This distribution is based on the data bank.

(LL) Nursing facility (NF). Effective October 1, 1990, skilled nursing facilities, skilled nursing facilities/intermediate care facilities and intermediate care facilities as defined in Chapter 198, RSMo participating in the Medicaid Program will all be subject to the minimum federal requirements found in section 1919 of the Social Security Act.

(MM) Occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility that completes a worksheet one (1) of cost report, version MSIR (7-93), determine the occupancy

rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certified portion for the same period, as determined from the desk audited and/or field audited cost report.

(NN) Patient care. This cost component includes the following lines from the cost report version MSIR-1 (7-93): lines 45-60, 77-85.

(OO) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(D) and hospital leave days per subsection (5)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(PP) Per diem. The daily rate calculated using this regulation's cost components and used in the determination of a facility's prospective and/or interim rate.

(QQ) Provider or facility. A nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility services to Title XIX-eligible recipients.

(RR) Prospective rate. The rate determined from the rate setting cost report.

(SS) Rate setting period. The full twelve (12)-month period in which a facility's prospective rate is determined. The rate setting period for a facility is determined from applicable regulations on or after July 1, 1990.

(TT) Reimbursement rate. A prospective or interim rate.

(UU) Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings;

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility; and

3. As used in this regulation, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity. Ownership or controlling interest is when an entity—

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership; and

C. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(VV) Replacement beds. Newly constructed beds never certified for Medicaid or previously licensed by the Division of Aging or the Department of Health and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

(WW) Renovations/major improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

(XX) Restricted funds. Funds, cash, cash equivalent or marketable securities, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(YY) Total facility size. Facility size plus increases minus decreases of licensed nursing facility beds plus calculated bed equivalents for renovations/major improvements.

(ZZ) Unrestricted funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a reimbursement rate but which are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and covered supplies required by federal or state law or regulation which must be provided by nursing facilities participating in the Title XIX program;

(B) Semiprivate room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition examples of which may be contagious infection, loud irrational speech, etc.;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the recipient's plan of care and prescribed by a physician. Periods of time during which a recipient is away from the facility visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of personal hygiene and routine care services furnished routinely and uniformly to all residents;

(F) All laundry services, including personal laundry;

(G) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(H) All consultative services required by federal or state law or regulations;

(I) All therapy services required by federal or state law or regulations;

(J) All routine care items including, but not limited to, those items specified in Appendix A to this regulation;

(K) All nursing services and supplies including, but not limited to, those items specified in Appendix A to this regulation;

(L) All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. Providers may not elect which nonlegend drugs in any of the four (4) cate-

gories to supply; any and all must be provided to residents as needed and are included in a facility's reimbursement rate; and

(M) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Noncovered Supplies, Items and Services. All supplies, items and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare or other third-party payor. Noncovered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a noncovered service and a Medicaid recipient or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the recipient or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(B) Supplies, items and services for which payment is made under other Medicaid programs directly to a provider(s) other than providers of the nursing facility services; and

(C) Supplies, items and services provided nonroutinely to residents for personal comfort or convenience.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area. Reasonableness of compensation shall be limited as prescribed in subsection (8)(Q).

2. Compensation shall mean the total benefit, within the limitations set forth in this regulation, received by the owner for the services rendered to the facility. This includes direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this regulation. Compensation must be paid (whether in cash,

negotiable instrument, or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the *Medicare Provider Reimbursement Manual*, Part 1, Section 906.4.

(B) Covered services and supplies as defined in section (5) of this regulation.

(C) Capital Assets.

1. Capital assets shall include historical costs that would be capitalized under GAAP. For example, historical costs would include, but not be limited to, architectural fees, related legal fees, interest and taxes during construction.

2. For purposes of this regulation, any asset or improvement costing greater than one thousand dollars (\$1,000) and having a useful life greater than one (1) year in accordance with American Hospital Association depreciable guidelines, shall be capitalized.

3. In addition to the American Hospital Association depreciable guidelines, mattresses shall be considered a capitalized asset and shall have a three (3)-year useful life.

(D) Depreciation—Vehicle.

1. An appropriate allowance for depreciation on vehicles which are a necessary part of the operation of a nursing facility is an allowable cost. One (1) vehicle per sixty (60) licensed beds is allowable. For example, one (1) vehicle is allowed for a facility with zero to sixty (0-60) licensed beds, two (2) vehicles are allowed for a facility with sixty-one to one hundred twenty (61-120) licensed beds, and so forth. Depreciation is treated as an administration cost and is reported on line 139 of the cost report, version MSIR-1 (7-93).

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospital Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

3. The basis of vehicle cost at the time placed in service shall be the lower of—

A. The book value of the provider;

B. Fair market value at the time of acquisition; or

C. The recognized Internal Revenue Service (IRS) tax basis.

4. The basis of a donated vehicle will be allowed to the extent of recognition of income resulting from the donation of the vehicle. Should a dispute arise between a provider and the division as to the fair market value at the time of acquisition of a depreciable vehicle, an appraisal by a third party is required. The appraisal cost will be the sole responsibility of the nursing facility.

5. Historical cost will include the cost incurred to prepare the vehicle for use by the nursing facility.

6. When a vehicle is acquired by trading in an existing vehicle, the cost basis of the new vehicle shall be the sum of undepreciated cost basis of the traded vehicle plus the cash paid.

(E) Insurance.

1. Property insurance. Insurance cost on property of the nursing facility used to provide nursing facility services. Property insurance should be reported on line 109 of the cost report version MSIR-1 (7-93).

2. Other insurance. Liability, umbrella, vehicle and other general insurance for the nursing facility should be reported on line 140 of the cost report version MSIR-1 (7-93).

3. Workers' Compensation insurance should be reported on the applicable payroll lines on the cost report for the employee salary groupings.

(F) Interest and Finance Costs.

1. Interest will be reimbursed for necessary loans for capital asset debt at the Chase Manhattan prime rate on September 1, 1994, plus two (2) percentage points. For replacement beds, additional beds and new facilities placed in service after August 31, 1995, the prime rate will be updated annually on the first business day of each September based on the Chase Manhattan prime rate plus two (2) percentage points.

2. Loans (including finance charges, prepaid costs and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the operation, maintenance or acquisition of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize loan costs (that is, lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest and discounts. The loan costs shall be amortized over the life of the loan on a straight line basis.

5. If loans for capital asset debt exceed the facility asset value the interest associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

6. The following is an illustration of how allowable interest is calculated:

Outstanding capital asset debt	\$2,500,000
Term of debt 25 years	
Interest rate (Chase Manhattan prime + 2%)	10 percent
Facility asset value	\$2,000,000
Discount	\$ 125,000
Loan costs	\$ 120,000

Allowable interest calculation—use the lesser of the facility asset value or the outstanding capital asset debt.

Other allowable borrowing costs:

Discount—\$2,000,000/\$2,500,000 × \$125,000 =	\$100,000
Loan Cost—\$2,000,000/\$2,500,000 × \$120,000 =	\$ 96,000
Allowable Interest—\$2,000,000 × 10% =	\$200,000
Discount—\$100,000/25 years =	\$ 4,000
Loan Cost—\$96,000/25 years =	\$ 3,840

Allowable Interest and Other Borrowing Costs \$207,840

7. Interest cost on vehicle debt for allowable vehicles per paragraph (7)(D)1. is treated as an administration cost and reported on line 139 of the cost report version MSIR-1 (7-93).

(G) Rental and Leases.

1. Capitalized leases, as defined by GAAP, will be reimbursed in accordance with subsections (7)(C) and (E).

2. Lease cost related to allowable vehicles per paragraph (7)(D)1. shall be treated as an administrative cost and be reported on line 139 of the cost report version MSIR-1 (7-93).

3. Operating leases, as defined by GAAP, will be part of the fair rental value system.

(H) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility used to provide nursing facility services.

(I) Value of Services of Employees.

1. Except as provided for in this regulation, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations shall not be an allowable cost, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost, provided that the services are not of a religious nature and are compensated. Costs of wardrobe and similar items shall not be allowable.

(J) Employee Benefits.

1. Retirement plans.

A. Contributions to IRS qualified retirement plans shall be an allowable cost.

B. Amounts funded to pension and qualified retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

2. Deferred compensation plans.

A. Contributions shall be allowable costs when, and to the extent that, these costs are actually paid by the provider. Provider payments for unfunded deferred compensation plans will be considered an allowable cost only when paid to the participating employee.

B. Amounts paid by organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

3. Types of insurance which are considered an allowable cost—

A. Credit life insurance (term insurance), if required as part of a mortgage loan agreement. An example, would be insurance on loans granted under certain federal programs;

B. Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be an employee benefit and is an allowable cost. This cost should be reported on the applicable payroll lines on the cost report for the employees salary groupings; and

C. Health, disability, dental, etc., insurances for employees/owners shall be allowable costs.

(K) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable, except for costs associated with nurse aide training and competency evaluation program.

2. Costs of education and training shall include travel costs, but will not include leaves of absence or sabbaticals.

(L) Organizational Costs.

1. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations; necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stockholders; and fees paid to states for incorporation.

2. Organizational costs shall be amortized ratably over a period of sixty (60)

months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

3. Where a provider is organized within a five (5)-year period prior to its entry into the program and has properly capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost under the program and shall be amortized over the remaining part of the sixty (60)-month period.

4. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(M) Advertising Costs. Advertising costs which are reasonable and appropriate are allowable. The costs must be a common and accepted occurrence for providing nursing facility services.

(N) Cost of Supplies and Services Involving Related Parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the cost report a provider shall identify related party suppliers and the type, the quantity and costs to the related party for goods and services obtained from each such supplier.

(O) Minimum Utilization. In the event the occupancy rate of a facility is below eighty-five percent (85%), the administration and capital cost components will be adjusted as though the provider experienced eighty-five percent (85%) occupancy. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Central Office/Home Office or Management Company Costs. The allowability of the individual cost items contained within central office/home office or management company costs will be determined in accordance with all other provisions of this regulation. The total of central office/home office and/or management company costs, as reported on lines 129 and 130 of the cost report, version MSIR (7-93), are limited to seven percent (7%) of gross revenues less contractual allowances.

(Q) Start-Up Costs. Expenses incurred prior to opening, as defined in HIM-15 as start-up costs, shall be amortized on a straight line method over sixty (60) months. The amortization shall be reported on the same line on the cost report as the original start-up costs are reported. For example, RN salary prior to opening would be amortized over

sixty (60) months and would be reported on line 49, RN.

(R) Reusable Items. Costs incurred for items, such as linen and bedding, but not limited to, shall be classified as inventory when purchased and expensed as the item is used.

(S) Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, the fee assessed to nursing facilities in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Nonallowable Costs. Costs not reasonably related to nursing facility services shall not be included in a provider's costs. Nonallowable costs include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants and purchased certificates of need;

(B) Bad debts, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are offsets to revenues and, therefore, not included in allowable costs;

(C) Capital cost increases due solely to changes in ownership;

(D) Charitable contributions;

(E) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this regulation;

(F) Costs such as legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(G) Directors' fees included on the cost report in excess of two hundred dollars (\$200) per month, per individual;

(H) Federal, state or local income and excess profit taxes, including any interest and penalties paid thereon;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on loans for intangible assets;

(M) Legal fees related to litigation involving the department and attorney's fees which are not related to the provision of nursing facility services, such as litigation related to disputes between or among owners, operators or administrators;

(N) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(O) Noncovered supplies, services and items as defined in section (6);

(P) Owner's compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated *Medicare Provider Reimbursement Manual* Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. Owners/administrators will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the high range. All others will be calculated on the median range.

2. The salary identified above will be apportioned on the basis of hours worked in the facility(ies), home office or management company as applicable to total hours in the facility(ies), home office or management company;

(Q) Prescription drugs;

(R) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals;

(S) Research costs;

(T) Resident personal purchases provided nonroutinely to residents for personal comfort or convenience;

(U) Salaries, wages or fees paid to non-working officers, employees or consultants;

(V) Cost of stockholder meetings or stock proxy expenses;

(W) Taxes or assessments for which exemptions are available;

(X) Value of services (imputed or actual) rendered by nonpaid workers or volunteers;

(Y) All costs associated with nurse aide training and competency evaluation program; and

(Z) Losses from disposal of assets.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report. These revenues are offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;
2. Sale of employee and guest meals;
3. Sale of medical abstracts;
4. Sale of scrap and waste food or materials;
5. Cash, trade, quantity, time and other discounts;
6. Purchase rebates and refunds;
7. Recovery on insured loss;

8. Parking lot revenues;

9. Vending machine commissions or profits;

10. Sales from supplies to individuals other than nursing facility recipients;

11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;

12. Barber and beauty shop revenue;

13. Private room differential;

14. Medicare Part B revenues;

A. Revenues received from Part B charges through Medicare intermediaries will be offset;

B. Seventy-five percent (75%) of the revenues received from Part B charges through Medicare carriers will be offset;

15. Personal services;

16. Activity income; and

17. Revenue recorded for donated services and commodities.

(B) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(C) Restricted funds designated by the donor for capital expenditures will not be offset from allowable expenses.

(D) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(E) As applicable, restricted and unrestricted funds will be offset in each cost component, excluding capital, in an amount equal to the cost component's proportionate share of allowable expense.

(F) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies, will not be offset.

(G) Gains on disposal of assets will not be offset from allowable expenses.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12)-month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the division an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose. Any substitute or computer generated cost report must have prior approval by the division.

3. All cost reports shall be completed in accordance with the requirements of this regulation and the cost report instructions.

Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this regulation.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period.

6. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's Medicaid participation agreement and if terminated retain all payments which have been withheld pursuant to this provision.

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted or available upon request includes, but is not limited to, the following:

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the division, the department or its agents;

G. Leases and/or rental agreements related to the activities of the provider if requested by the division, the department or its agents;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;



L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

8. Cost reports must be fully, clearly and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the division's request, payments may be withheld from the facility until the information is submitted.

9. Under no circumstances will the division accept amended cost reports for rate determination or rate adjustment after the date of the division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a commissioned notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity: Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided or at the central office/home office if located in the state of Missouri. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

4. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the state of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering, at a minimum, the first two (2) full twelve (12)-month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and generally accepted auditing standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings and Statement of Cash Flow. For example, a provider begins participation in the Medicaid program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September.

That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve (12)-month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve (12)-month cost report, shall be audited. The audits shall be done by an independent certified public accountant.

(E) Change in Provider Status.

1. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership or termination of participation in the Medicaid Program, the division will withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership or termination. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

2. If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership and a cost report ending with the date of the change of control or ownership, upon learning of a change of control or ownership, thirty thousand dollars (\$30,000) of the next available full month Medicaid payment, after learning of the change of control or ownership will be withheld from the provider identified in the current Medicaid participation agreement until a cost report is filed. If the Medicaid payment is less than thirty thousand dollars (\$30,000), the entire payment will be withheld. Once the cost report, prepared in accordance with this regulation, is received the payment will be released to the provider identified in the current Medicaid participation agreement.

3. The Division of Medical Services may, at its discretion, delay the withholding of funds specified in paragraphs (10)(E)1. and 2. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling provider may provide adequate assurances. The buying provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold thirty thousand dollars (\$30,000) if the cost report is not timely filed.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the nursing facility, the revenues, expenses, statistical and financial



records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity(ies) that own, control or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year-to-year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this regulation, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this regulation.

(11) Cost Components and Per-Diem Calculation. The division will use a cost report which has an ending date in calendar year 1992 which is on file with the division as of December 31, 1993. No amended cost report will be accepted after December 31, 1993. If a facility has more than one (1) cost report with periods ending in calendar year 1992, the cost report covering a full twelve (12)-month period ending in calendar year 1992 will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in calendar year 1992 will be used.

(A) Patient Care. Each nursing facility's patient care per diem shall be the lower of—

1. Allowable cost per patient day for patient care as determined by the division from the 1992 cost report tended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6%; or

2. The per-diem ceiling of one hundred twenty percent (120%) of the patient care median determined by the division from the data bank.

(B) Ancillary. Each nursing facility's ancillary per diem will be the lower of—

1. Allowable cost per patient day for ancillary as determined by the division from the 1992 cost report, tended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6%; or

2. The per-diem ceiling of one hundred twenty percent (120%) of the ancillary median determined by the division from the data bank.

(C) Administration. Each nursing facility's administration per diem shall be the lower of—

1. Allowable cost per patient day for administration as determined by the division from the 1992 cost report, tended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6% and adjusted for minimum utilization, if applicable, as described in subsection (7)(O); or

2. The per-diem ceiling of one hundred ten percent (110%) of the administration median determined by the division from the data bank.

(D) Capital. Each nursing facility's capital per diem shall be determined using the fair rental value system as follows:

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the 1992 desk audited and/or field audited cost report;

(II) Determine the number of increased licensed beds after the end of the facility's 1992 desk audited and/or field audited cost report but prior to July 1, 1994;

(III) Determine the bed equivalency for renovations/major improvements prior to July 1, 1994, by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. The cost must be at least the asset value per bed for the year of the renovation/major improvement. For example, a renovations/major improvements cost of two hundred thousand (\$200,000) is equal to six (6) beds. (\$200,000/\$32,330 equals 6.19 beds rounded to 6 beds);

(IV) Determine the number of decreased licensed beds after the end of the facility's 1992 cost report but prior to July 1, 1994; and

(V) Sum of (I), (II), (III) less (IV) times the asset value is the Total Asset Value.

B. Determine the reduction for age by multiplying the age of the beds by one percent (1%) up to forty percent (40%). For multiple licensing dates, the result of the weighted average age calculation will be limited to forty percent (40%).

(I) The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, a facility with original licensure in 1977 of sixty (60) beds and an additional licensure of sixty (60) beds in 1982

and ten (10) beds in 1993, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
Total		130	1750

Weighted Average Age—1750/130 beds = 13.5 years rounded to 14 years. This results in a reduction for age of the beds of 14%.

(II) The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being replaced first. For example, a facility with one hundred twenty (120) beds licensed in 1978 with replacement of sixty (60) beds in 1988, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1978	16	60	960
1988	6	60	360
Total		120	1320

Weighted Average Age—1320/120 = 11 years. This results in a reduction for age of the beds of 11%.

(III) The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being delicensed first. For example, a facility with original licensure in 1977 of sixty (60) beds, additional licensure of sixty (60) beds in 1982 and ten (10) beds in 1993 and a reduction of 10 (10) beds in 1985, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
1985*	17	(10)	(170)
Total		120	1580

\* reduction of 1977 beds

Weighted Average Age—1580/120 beds = 13.2 years rounded to thirteen (13) years. This results in a reduction for age of the beds of 13%.

(IV) The age of the beds equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a one hundred twenty (120) bed facility licensed in 1978 undertakes two (2) renovations: \$200,000 in 1983 and \$100,000 in



1993. The asset value per bed is \$32,330. The bed equivalency is six (6) beds for 1983 and three (3) beds for 1993, the reduction percentage is calculated as follows:

Licensure/ Construction		Age × Beds	
Year	Age	Beds	Beds
1978	16	120	1920
1983	11	6	66
1993	6	<u>1</u>	<u>3</u>
Total		120	1320

Weighted Average Method—1989/129 = 15.42 years rounded to 15 years. This results in a reduction for age of beds of 15%.

C. The facility asset value is subparagraph (11)(D)1.A. less subparagraph (11)(D)1.B.

D. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half percent (2.5%) is based on a forty (40)-year life.

E. The following is an illustration of how subparagraphs (11)(D)1.A. and B. and (11)(D)1.C. and D. determines the rental value:

(I) Total facility size	174 beds
Weighted average age of the beds	23 years
Capital asset debt	\$2,371,094
Asset value	\$ 32,330

(II) The total asset value is the product of the total facility size times the asset value;

Total facility size	174
Asset value	× \$32,330
Total asset value	\$5,625,420

(III) Facility asset value is total asset value less the reduction for age of the beds; and

Reduction for age (23%)	\$1,293,847
Facility asset value	\$4,331,573

(IV) Rental value is the facility asset value multiplied by 2.5%.

Rental value	× 2.5%	\$108,289
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2. Rate of return.

A. Reduce the facility asset value by the capital asset debt, but not less than zero (0), times the percentage of return. The percentage of return is the yield for the thirty (30)-year Treasury Bond as reported by the Federal Reserve Board and published in the *Wall Street Journal* for the week ending September 2, 1994, plus two percentage (2%) points. The rate is 7.48% for the week ending September 2, 1994, plus 2% for a total of 9.48%.

B. The debt associated with increases in licensed beds or renovations/major improvements after the end of the facility's

1992 desk audited and/or field audited cost report and prior to July 1, 1994, will be added to the capital asset debt from the 1992 desk audited and/or field audited cost report. The facility shall provide adequate documentation to support the additional debt as required in paragraph (7)(E)2. If adequate documentation is not provided to support the additional asset debt, it will be assumed to equal the facility asset value.

C. The following is an illustration of how subparagraph (11)(D)2.A. is calculated:

Facility asset value	\$4,331,573
Capital asset debt	\$2,371,094
	\$1,960,479
Percentage of return	× 9.48%
Rate of return	\$ 185,853

3. Computed interest and pass through expenses.

A. Add property insurance (line 109) and property taxes (lines 111 and 112) tendered by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6%. Also add interest subject to limits identified in subsection (7)(F). These lines are found in the cost report, version MSIR-1 (7-93).

B. The following is an illustration of how subparagraph (11)(D)3.A. is calculated:

Computed interest	\$207,840
Insurance	\$ 7,594
Property taxes	\$ 40,548
Pass through expenses	\$ 48,142

4. Capital component per-diem calculation.

A. A per diem is calculated by dividing the sum of rental value, rate of return and computed interest by the number of beds determined in subparagraph (11)(D)1.A. times three hundred sixty-five (365) adjusted by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's occupancy from the 1992 desk audited and/or field audited cost report. The following is an illustration of how subparagraph (11)(D)4.A. is calculated:

Rental value	\$108,289
Rate of return	\$185,853
Computed interest	\$207,840
Total	\$501,982
Divided by annualized patient days	56,077
Capital per diem	\$ 8.98

B. A per diem is calculated by dividing the pass through expenses by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's patient days from the 1992 desk audited and/or field

audited cost report. The following is an illustration of how subparagraph (11)(D)4.B. is calculated:

Pass through expenses	\$48,142
Patient days	\$55,146
Pass through per diem	\$ .87

C. The capital component per diem is the sum of subparagraphs (11)(D)4.A. and (11)(D)4.B.

Capital per diem	\$8.95
Pass through per diem	\$ .87
Total capital component per diem	\$9.82

(E) Working Capital Allowance. Each nursing facility's working capital per diem shall be equal to one and one-tenth (1.1) months of each facility's per diem for patient care, ancillary and administration times the Chase Manhattan prime rate on September 1, 1994, plus two (2) percentage points. The following is an illustration of how subsection (11)(E) is calculated:

Patient care	\$30.00
Ancillary	\$ 7.00
Administration	\$20.00
Total per diem	\$57.00
Divided by 12 months	12
	\$ 4.75
Times 1.1 months	1.1
	\$ 5.23

Times Prime + 2% (Chase Manhattan plus 2%)	10%
Working capital allowance per day	\$ .52

(F) The following is an illustration of how subsections (11)(A)–(E) determine the per-diem rate:

	Allowable	Cost Ceiling	Per Diem
Patient Care	\$38.00	\$40.00	\$38.00
Ancillary	\$ 8.00	\$ 6.00	\$ 6.00
Administration	\$12.00	\$11.00	\$11.00
Capital (FRV)			\$ 9.82
Working capital allowance			\$ .52
Total per diem			\$65.34

(12) Reimbursement Rate Determination. A facility's reimbursement rate shall be determined by the division as described in sections (11)–(14), subject to limitations prescribed elsewhere in this regulation. Any facility with an interim rate on December 31, 1994, shall be granted an interim rate effective for services on and after January 1, 1995, as prescribed in subsection (4)(EE), if applicable. A prospective rate determined from this regulation shall be retroactively effective for services beginning on the first day of the facility's second twelve (12)-month fiscal year but not earlier than January 1, 1995, and shall

replace the interim on and after January 1, 1995.

(A) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, and with a 1992 cost report on file with the division as of December 31, 1993, with a rate setting period ending in calendar year 1992 or prior shall be granted a prospective rate effective for service dates on and after January 1, 1995. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. The prospective rate shall be the greater of the following:

1. The per-diem rate as determined in section (11); or

2. The prospective rate in effect for services rendered on January 1, 1994.

(B) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending in calendar year 1993 shall have their prospective rate for services after December 31, 1994, based on the 1993 rate setting cost report. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per-diem rate as calculated in accordance with section (11), except the 1993 desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994 and nine (9) months of 1995 of 10.6% will be replaced with the 1994 and 1995 HCFA Market Basket Index of 3.4% and 3.3% respectively for a total of 6.7%; or

2. The prospective rate in effect for services rendered on January 1, 1994.

(C) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending in calendar year 1994 shall have their prospective rate for services after December 31, 1994, based on the 1994 rate setting cost report. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per-diem rate as calculated in accordance with section (11), except the 1994 desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994 and nine (9) months of 1995 of 10.6% will be replaced with the 1995 HCFA Market Basket Index of 3.3%; or

2. The prospective rate in effect for services rendered on January 1, 1994.

(D) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending after December 31, 1994, but before December 1, 1995, shall have their prospective rate for services after December 31, 1994, based on the rate setting cost report ending after December 31, 1994 but before December 1, 1995. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per-diem rate as calculated in accordance with section (11), except the fiscal year ending after December 31, 1994 but prior to December 1, 1995, desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994 and nine (9) months of 1995 will not be applied; or

2. The prospective rate in effect for services rendered on December 31, 1994.

(E) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending after November 30, 1995, shall have their prospective rate based on a rate setting cost report ending after November 30, 1995. A prospective rate will be effective for services on or after the first day of the rate setting period as determined in section (11), except the desk audited and/or field audited cost report ending after November 30, 1995, will be used. The 1993, 1994 and nine (9) months of 1995 HCFA Market Basket Index will not be applied.

(F) A facility entering the Medicaid program after December 31, 1994, shall receive an interim rate as defined in subsection (4)(EE) to be effective on the initial date of Medicaid certification. A prospective rate shall be determined in accordance with section (11) from the desk audited and/or field audited facility fiscal year cost report which covers the second full twelve (12)-month fiscal year following the facility's initial date of Medicaid certification. The HCFA Market

Basket Index for 1993, 1994 and nine (9) months of 1995 will not be applied. This prospective rate shall be retroactively effective and shall replace the interim rate for services beginning on the first day of the facility's second full twelve (12)-month fiscal year.

(G) A facility with a valid Medicaid participation agreement in effect after December 31, 1994, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which reenters the Medicaid Program, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to reentry into the program as described in subsection (13)(A). This prospective rate shall be effective for service dates on and after the effective date of the reentry following a voluntary or involuntary termination.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section.

(A) Global Per-Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per-diem rate adjustments. Global per-diem rate adjustments shall be added to the specified cost component ceiling.

1. FY-96 negotiated trend factor—

- A. Facilities with either an interim rate or prospective rate in effect on October 1, 1995, shall be granted an increase to their per diem effective October 1, 1995, of 4.6% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

- B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of this regulation.

2. FY-97 negotiated trend factor—

- A. Facilities with either an interim rate or prospective rate in effect on October 1, 1996, shall be granted an increase to their per diem effective October 1, 1996, of 3.7% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

- B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1,



1995, shall have their increase determined by subsection (3)(S) of this regulation.

3. NFRA. Effective October 1, 1996, all facilities with either an interim rate or a prospective rate shall have its per diem adjusted to include the current NFRA as an allowable cost in its reimbursement rate calculation.

4. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on November 1, 1996, shall be granted an increase to their per diem effective November 1, 1996, of two dollars and forty-five cents (\$2.45) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty-cent (50¢) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator and assistant administrator.

5. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar and ninety-eight cents (\$1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty-cent (40¢) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator and assistant administrator.

6. FY-98 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1997, shall be granted an increase to their per diem effective October 1, 1997, of 3.4% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1. and the property insurance and property taxes detailed in paragraph (11)(D)3. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of this regulation.

7. FY-99 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1998, shall be granted an increase to their per diem effective October 1, 1998, of 2.1% of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., the property insurance and property taxes detailed in para-

graph (11)(D)3. of this regulation and the minimum wage adjustments detailed in paragraphs (13)(A)4. and (13)(A)5.; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on October 1, 1998, shall have their increase determined by subsection (3)(S) of this regulation.

8. FY-2000 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 1999, shall be granted an increase to their per diem effective July 1, 1999, of 1.94% of the cost determined in subsections (11)(A), (11)(B), (11)(C), the property insurance and property taxes detailed in paragraph (11)(D)3. and the minimum wage adjustments detailed in paragraphs (13)(A)4. and (13)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. that is in effect on July 1, 1999, shall have their increase determined by subsection (3)(S) of this regulation.

(B) Special Per-Diem Rate Adjustments. Special per-diem rate adjustments may be added to a qualifying facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Patient care incentive. Each facility with a prospective rate on or after January 1, 1995, shall receive a per-diem adjustment equal to ten percent (10%) of the facility's allowable patient care per diem subject to a maximum of one hundred thirty percent (130%) of the patient care median when added to the patient care per diem as determined in subsection (11)(A). This adjustment will not be subject to the cost component ceiling of one hundred twenty percent (120%) for the patient care median.

2. Ancillary incentive. Each facility with a prospective rate on or after January 1, 1995, and which meets one (1) of the following criteria shall receive a per-diem adjustment:

A. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is below ninety percent (90%) of the ancillary median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) and ninety percent (90%) of the ancillary median. The following is an illustration of how the ancillary per-diem adjustment is calculated:

120% of median	\$6.62
90% of median	\$4.97
Difference	\$1.65
1/2 the difference	<u>  .825</u>
Per-diem adjustment	\$ .83

B. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is between ninety percent (90%) and one hundred twenty percent (120%) of the median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) of the median and the facility's allowable ancillary per diem. The following is an illustration of how the ancillary per-diem adjustment is calculated:

90% of median	\$4.97
120% of median	\$6.62
Ancillary per diem	\$5.21
Difference	\$1.41
1/2 the difference	<u>  .705</u>
Per-diem adjustment	\$ .71

3. Multiple component incentive. Each facility with a prospective rate on or after January 1, 1995, and meets the following criteria shall receive a per-diem adjustment:

A. If the sum of the facility's patient care per diem and ancillary per diem, as determined in subsections (11)(A) and (B), is greater than or equal to sixty percent (60%) but less than or equal to eighty percent (80%), rounded to four (4) decimal places (.5985 or .8015 would not receive the adjustment), of the facility's total per diem, the adjustment is as follows:

Percent of Total Per-Diem Rate	Incentive
< 60%	\$0.00
> or = 60% but < 65%	\$1.15
> or = 65% but < 70%	\$1.30
> or = 70% but < 75%	\$1.45
> or = 75% but < or 80% =	\$1.60

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (13)(B)3.A. and the following calculation is greater than seventy-five percent (75%), rounded to four (4) decimal places (.7485 would not receive the adjustment): Medicaid days divided by the licensed nursing facility patient days from the facility's desk audited and/or field audited 1992 cost report. The adjustment is as follows:

Calculated Percentage	Incentive
< 75%	\$0.00
> or = 75% but < 80%	\$0.15
> or = 80% but < 85%	\$0.30
> or = 85% but < 90%	\$0.45
> or = 90% but < 95%	\$0.60
> or = 95%	\$0.75

4. 1967 *Life Safety Code* (LSC). Currently certified nursing facilities that must

comply with a recent interpretation of paragraph 10-133 of the 1967 LSC which requires corridor walls to extend to the roof deck or achieve equivalency under the Fire Safety Evaluation System (FSES) will be reimbursed the reasonable and necessary cost to meet those standards required for compliance through their reimbursement rate. The reimbursement shall not be effective until the Division of Aging has confirmed that the corrective action to comply with the 1967 LSC or FSES is operational and has reviewed the cost for compliance. Fire sprinkler systems shall be reimbursed over a depreciation life of twenty-five (25) years, and other alternative corrective action will be reimbursed over a depreciable life of fifteen (15) years. The division will use a desk audited and/or field audited cost report with the latest period ending in calendar year 1992 which is on file with the division as of December 31, 1993. This adjustment will be computed based on the documented cost submitted to the division as follows:

A. Depreciation. The cost incurred for the approved corrective action to continue in compliance divided by the depreciable useful life;

B. Interest. The interest cost incurred to finance this project shall be documented by a statement from the lending institution detailing the total interest cost of the loan period. The total interest cost will be divided by the loan period on a straight line basis; and

C. The total of subparagraph (13)(B)4.A. and B. will be divided by twelve (12) and then multiplied by the number of months covered by the 1992 cost report. This amount will be divided by the greater of actual patient days from the 1992 cost report or eighty-five percent (85%) of the licensed bed days from the 1992 cost report.

5. Any facility that had a 1967 LSC adjustment included in their December 31, 1994 reimbursement rate shall have that adjustment added to their January 1, 1995 reimbursement rate.

6. Replacement beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Division of Aging or the Department of Health. The facility shall provide documentation from the Division of Aging or the Department of Health that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (fair rental value (FRV)) prior to the replacement

beds being placed in service and the capital component per diem (FRV) including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

7. Additional beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the additional beds being placed in service and the capital component per diem (FRV) including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is calculated for the additional beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

8. Extraordinary circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

A. When the provider can show that it incurred higher costs due to circumstances beyond its control, the circumstances were not experienced by the nursing home industry in general and the costs have a substantial cost effect;

B. Extraordinary circumstances include:

(I) Natural disasters such as fire, earthquakes and flood that are not covered by insurance and that occur in a federally declared disaster area; and

(II) Vandalism and/or civil disorder that are not covered by insurance; and

C. The rate increase shall be calculated as follows:

(I) The one (1)-time costs, (costs that will not be incurred in future fiscal years):

(a) To determine what portion of the incurred costs will be paid, the division will use the patient occupancy days from latest available quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstances occurred; and

(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)8. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived.

(II) For ongoing costs (costs that will be incurred in future fiscal years): Ongoing annual costs will be divided by the greater of: annualized (calculated for a twelve (12)-month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost component ceiling. The rate adjustment, subject to ceiling limits will be added to the prospective rate.

(III) For capitalized costs, a capital component per diem (FRV) will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the extraordinary circumstances and the capital component per diem (FRV) including the extraordinary circumstances.

9. Quality Assurance Incentive.

A. Each nursing facility with an interim or prospective rate on or after July 1, 2000, shall receive a per-diem adjustment of

\$3.20. The Quality Assurance Incentive adjustment will be added to the facility's current rate.

B. The Quality Assurance Incentive per-diem increase shall be used to increase the expenditures to a nursing facility's direct patient care costs. Direct patient care costs include all expenses in the patient care cost component (i.e., lines 46 through 69 of Schedule B in the Title XIX Cost Report). Any increases in wages and benefits already codified in a collective bargaining agreement in effect as of July 1, 2000, will not be counted towards the expenditure requirements of the Quality Assurance Incentive as stated above. Nursing facilities with collective bargaining agreements shall provide such agreements to the division.

10. High Volume Adjustment. Effective for dates of service July 1, 2000, a high volume adjustment shall be granted to qualifying providers. A provider must qualify each July 1, the beginning of each state fiscal year (SFY), for the high volume adjustment and the adjustment will be effective for services rendered during the SFY, July 1 through June 30. For a provider who has a high volume adjustment on June 30, but does not qualify for the high volume adjustment on July 1 of the subsequent SFY, that provider's prospective rate will be reduced by the amount of the high volume adjustment included in the facility's prospective rate in effect June 30.

A. Each facility with a prospective rate on or after July 1, 2000, and which meets all of the following criteria shall receive a per-diem adjustment:

(I) Have on file at the division a full twelve (12)-month cost report ending in the third calendar year prior to the state fiscal year in which the adjustment is being determined (i.e., for SFY 2001, the third prior year would be 1998, for SFY 2002, the third prior year would be 1999, etc.);

(II) The Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds eighty-five percent (85%) of the total patient days for all nursing facility licensed beds;

(III) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care, ancillary and administration cost components, as set forth in paragraphs (11)(A)1., (11)(B)1. and (11)(C)1., exceeds the per-diem ceiling for each cost component in effect at the end of the cost report period; and

(IV) Government owned or operated facilities shall not be eligible for this adjustment.

B. The adjustment will be equal to ten percent (10%) of the sum of the per-diem

ceilings for the patient care, ancillary and administration cost components in effect on July 1 of each year.

C. The division may reconstruct and redefine the qualifying criteria and payment methodology for the high volume adjustment.

(C) Conditions for prospective rate adjustments. The division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

1. Fraud, misrepresentation, errors. When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's prospective rate may be both retroactively and prospectively reduced if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher, prospective rate than the facility would have received in the absence of such information. No decision by the division to impose a rate adjustment in the case of fraudulent, misrepresented or inaccurate information shall in any way affect the division's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented or inaccurate information reported did not result in establishment of a higher prospective rate than the facility would have received in the absence of this information also does not affect the division's ability to impose any sanctions authorized by statute or regulation;

2. Decisions of the Administrative Hearing Commission, or settlement agreements approved by the Administrative Hearing Commission;

3. Court order; and

4. Disallowance of federal financial participation.

(14) Exceptions.

(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of less than one thousand (1,000) patient days for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level of care by the state in which the provider is located; or

2. For providers which provided services of one thousand (1,000) or more patient

days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of:

A. The rate paid for comparable services and level of care by the state in which the provider is located; or

B. The rate as calculated in sections (11)–(13).

(C) The Title XIX reimbursement rate for hospital based providers, which provide services of less than one thousand (1,000) patient days for Missouri Title XIX recipients, relative to their fiscal year, are exempt from filing a cost report as prescribed in section (10).

1. For hospital based nursing facilities that have less than one thousand (1,000) Medicaid patient days, the rate base cost report will not be required. The prospective rate will be the sum of the ceilings for patient care, ancillary and administration, working capital allowance, and the median per diem for capital. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

2. For hospital based nursing facilities with a provider agreement in effect on December 31, 1994, a prospective rate shall be set by one (1) of the following:

A. If the hospital based nursing facility notifies the division, in writing, and request that their prospective rate be determined from their 1992 desk audited and/or field audited cost report as defined in sections (11)–(13); or

B. The sum of the ceilings for patient care, ancillary, administration and working capital allowance, and the median per diem for capital from the permanent capital per diem in effect January 1, 1995. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

(15) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this regulation, the division may also impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or regulations.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(16) Appeals. In accordance with sections 208.156, RSMo and 622.055, RSMo providers may seek hearing before the Administrative Hearing Commission of final decisions of the director or the division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and other applicable payments.

(18) Provider Participation. Payments made in accordance with the standards and methods described in this regulation are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the regulation at least to the extent these services are available to the general public.

(19) Transition. Cost reports used for rate determination shall be adjusted by the division in accordance with the applicable cost principles provided in this regulation.

**APPENDIX A  
COVERED SUPPLIES AND SERVICES  
PERSONAL CARE**

- Baby powder
- Bedside tissues
- Bibs, all types
- Deodorants
- Disposable underpads of all types
- Gowns, hospital
- Hair care, basic including washing, cuts, sets, brushes, combs, nonlegend shampoo
- Lotion, soap, and oil
- Oral hygiene including denture care, cups cleaner, mouthwashes, toothbrushes and paste
- Shaves, shaving cream and blades
- Nail clipping and cleaning routine

**EQUIPMENT**

- Arm slings
- Basins
- Bathing equipment
- Bed frame equipment including trapeze bars and bedrails
- Bed pans, all types
- Beds, manual, electric
- Canes, all types
- Crutches, all types
- Foot cradles, all types
- Glucometers
- Heat cradles
- Heating pads
- Hot pack machines
- Hypothermia blanket
- Mattresses, all types
- Patient lifts, all types
- Respiratory equipment: compressors, vaporizers, humidifiers, IPPB machines, nebulizers, suction equipment and related supplies, etc.

- Restraints
- Sand bags
- Specimen container, cup or bottle
- Urinals, male and female
- Walkers, all types
- Water pitchers
- Wheelchairs, standard, geriatric and roll-about

**NURSING CARE/PATIENT CARE  
SUPPLIES**

- Catheter, indwelling and nonlegend supplies
- Decubitus* ulcer care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads and/or turning frames, heel protectors, donuts and sheepskins
- Diabetic blood and urine testing supplies
- Douche bags
- Drainage sets, bags, tubes, etc.
- Dressing trays and dressings of all types
- Enema supplies
- Gloves, nonsterile and sterile
- Ice bags
- Incontinence care including pads, diapers and pants
- Irrigation trays and nonlegend supplies
- Medicine droppers
- Medicine cups
- Needles including, but not limited to, hypodermic, scalp, vein
- Nursing services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel
- Nursing supplies: lubricating jelly, betadine, benzoin, peroxide, A and D Ointment, tapes, alcohol, alcohol sponges, applicators, dressings and bandages of all types, cottonballs, and aerosol merthiolate, tongue depressors
- Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures, and bags
- Suture care including trays and removal kits
- Syringes, all sizes and types including ascepto
- Tape for laboratory tests
- Urinary drainage tube and bottle

**THERAPEUTIC AGENTS AND  
SUPPLIES**

- Supplies related to internal feedings
- I.V. therapy supplies: arm boards, needles, tubing, and other related supplies
- Oxygen (portable or stationary), oxygen delivery systems, concentrators, and supplies
- Special diets

*AUTHORITY: sections 208.153, 208.159 and 208.201, RSMo 1994. \* Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. Emergency amendment filed Sept. 1, 1995, effective Oct. 1, 1995, expired March 28, 1996. Amended: Filed Sept. 1, 1995, effective March 30, 1996. Amended: Filed Dec. 22, 1995, effective Aug. 30, 1996. Amended: Filed Feb. 1, 1996, effective Sept. 30, 1996. Emergency amendment filed Sept. 20, 1996, effective Oct. 1, 1996, expired March 29, 1997. Emergency amendment filed Oct. 22, 1996, effective Nov. 1, 1996, expired April 29, 1997. Emergency amendment filed Aug. 12, 1997, effective Sept. 1, 1997, expired Feb. 27, 1998. Amended: Filed Aug. 12, 1997, effective Feb. 28, 1998. Emergency amendment filed Sept. 19, 1997, effective Oct. 1, 1997, expired March 29, 1998. Amended: Filed Sept. 25, 1997, effective March 30, 1998. Amended: Filed March 2, 1998, effective Oct. 30, 1998. Amended: Filed July 15, 1998, effective Feb. 28, 1999. Emergency amendment Sept. 21, 1998, effective Oct. 1, 1998, expired March 29, 1999. Amended: Filed Sept. 21, 1998, effective May 30, 1999. Emergency amendment filed Sept. 20, 1999, effective Oct. 1, 1999, expired March 29, 2000. Amended: Filed Aug. 30, 1999, effective March 30, 2000. Emergency amendment filed July 18, 2000, effective July 28, 2000, expired Jan. 24, 2001. Amended: Filed June 29, 2000, effective Feb. 28, 2001. Amended: Filed Oct. 6, 2000, effective April 30, 2001.*

*\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; 208.159, RSMo 1979; and 208.201, RSMo 1987.*

**13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/MR Services**

*PURPOSE: This rule establishes a payment plan for nonstate-operated intermediate care facility/mentally retarded services. The plan describes principles to be followed by Title XIX intermediate care facility/mentally retarded providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing the cost reports.*

*PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this*

rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) Objectives. This rule establishes a payment plan for nonstate-operated intermediate care facility/mentally retarded (ICF/MR) services.

(2) General Principles.

(A) The Missouri Medical Assistance Program shall reimburse qualified providers of ICF/MR services based solely on the individual Medicaid recipient's days of care (within benefit limitations) multiplied by the facility's Title XIX per-diem rate less any payments made by recipients.

(B) Effective November 1, 1986, the Title XIX per-diem rate for all ICF/MR facilities participating on or after October 31, 1986, shall be the lower of—

1. The average private pay charge;

2. The Medicare per-diem rate, if applicable;

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve (12)-month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the Medicaid Program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement; and

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection (3)(K) of this rule, will be exempt from paragraph (2)(B)3. and the rate shall be determined in accordance with applicable provisions of this rule.

(C) In no case may the per-diem reimbursement rate under the provisions of this rule exceed the level-of-care ceiling.

(D) This plan has an effective date of November 1, 1986, at which time prospective per-diem rates shall be calculated for the remainder of the state's FY-87 and future fiscal years. Per-diem rates established by updating facilities' base years to FY-85 may be subject to retroactive and prospective adjustment based on audit of the facilities' new base year period.

(E) The Title XIX per-diem rates as determined by this plan shall apply only to ser-

vices furnished on or after November 1, 1986.

(3) Definitions.

(A) Allowable cost areas. Those cost areas which are allowable for allocation to the Medicaid Program based upon the principles established in this rule. The allowability of cost areas, not specifically addressed in this rule will be based upon criteria of the *Medicare Provider Reimbursement Manual* (HIM-15) and section (7) of this rule.

(B) Average private pay charge. The average private pay charge is the usual and customary charge for non-Medicaid patients determined by dividing total non-Medicaid days of care into total revenue collected for the same service that is included in the Medicaid per-diem rate, excluding negotiated payment methodologies with the Veterans Administration and the Missouri Department of Mental Health.

(C) Committee. The advisory committee defined in subsection (6)(A) of this rule.

(D) Cost report. The cost report shall detail the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the department.

(E) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(F) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(G) Effective date.

1. The plan effective date shall be November 1, 1986.

2. The effective date for rate adjustments granted in accordance with section (6) of this rule shall be for dates of service beginning the first day of the month following the director's, or his/her designee's, final determination on the rate.

(H) ICF/MR. Nonstate-operated facilities certified to provide intermediate care for the mentally retarded under the Title XIX program.

(I) Level-of-care ceiling. One hundred thirty-five percent (135%) of the weighted mean rate for the nonstate-operated ICF/MR level-of-care group in effect on March 1, 1990; provided, that on July 1, 1990, and annually after that the per-diem reimbursement rate as adjusted by the negotiated trend factor may be used as the basis for the level-of-care ceiling computed for the subsequent year.

(J) Medicare rate. This is the allowable cost of care permitted by Medicare standards and principles of reimbursement.

(K) New construction. Newly built facilities or parts, for which an approved Certificate of Need (CON) or applicable

waivers were obtained and which were newly completed and operational on or after November 1, 1986.

(L) New owners. Original owners of new construction.

(M) Providers. A provider under the Prospective Reimbursement Plan is a nonstate-operated ICF/MR facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible recipients. Facilities certified to provide intermediate care services to the mentally retarded under the Title XIX program may be offered a Medicaid participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for mentally retarded residents and 2) there is no other licensed residential living facility for mentally retarded individuals within a radius of one-half (1/2) mile of the facility seeking participation in the Medicaid Program.

(N) Reasonable and adequate reimbursement. Reimbursement levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

(O) Related parties. Parties are related when—

1. An individual or group, regardless of the business structure of either, where, through their activities, one (1) individual's or group's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

2. One (1) or more persons has an ownership or controlling interest in a party, and the person(s) or one (1) or more relatives of the person(s) has an ownership or controlling interest in the other party. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in section (3), the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock or in the profits of an entity;

C. Ownership or controlling interest is when a person or corporation(s)—